



The California Managed Risk Medical Insurance Board

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Clifford Allenby, Chair

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Richard Figueroa

Sophia Chang, M.D., M.P.H

Ex Officio Members

Jack Campana

Kimberly Belshé

Dale E. Bonner

The following health model contract amendment was updated per the Board's direction to staff at the October 24, 2007, meeting



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HEALTH

Date: October ____, 2007

To: Healthy Families Program Participating Health, Dental, and Vision Plans

From: Denise M. Arend
Chief Deputy Director

Re: Healthy Families Program 2008-09 Contract Amendment Package

This electronic package provides the instructions and documents for completing the 2008-09 amendment to your 2005-08 Healthy Families Program (HFP) contract. **All documents, except your rate submission, are due via email by December 7, 2007 and one hard copy in a three-ring binder mailed by December 11, 2007. Rate development templates are due via email by January 7, 2008, and one signed Actuarial Certification mailed by January 9, 2008.**

CONTRACT LANGUAGE CHANGES

The attached e-files of Exhibit A and Exhibit B include contract language changes which incorporate some, but not all, plans' suggestions on the draft changes considered at the Board's September 19, 2007 meeting.

The final language changes are summarized below.

EXHIBIT A

I. Introduction, section D, Changing Health Care Providers, paragraphs 2 and 3

2. *Clarifies when health care providers are added or deleted from the Contractor's Provider Directory, if this activity either opens a new zip code to the coverage contemplated or would materially impair the Contractor's capacity to perform under the Agreement, a copy of the documentation required in I.C.2 must be provided when it is submitted to the state licensing agency.*

3. *Adds the provision that requires Contractors to maintain the availability of fee-for-service payment arrangements for subscribers in conformance with Health and Safety Code section 1373.96(d)(2).*

II. Enrollment, section A, Eligibility, paragraph 1

1. *Clarifies that the State will conduct all eligibility determinations and that the Contractor shall not attempt to conduct its own eligibility investigations or inquiries.*

II. Enrollment, section F, Identification Cards, Provider Directory, and Evidence of Coverage Booklet, paragraph 3.d

- 3.d. *Clarifies the Contractor's requirement to submit two print copies and one electronic copy on compact disk of an updated Evidence of Coverage booklet (or amended pages) as well as one print copy of the updated Provider Directory.*

II. Enrollment, section J, Enrollment Data, paragraph 1

1. *Clarifies that the State is the official record holder of subscriber information and that the Contractor shall not make any changes to the subscriber information unless the changes are transmitted by the State.*

II. Enrollment, section M, Public Awareness, paragraph 5

5. *Adds the requirement that Contractor's designated staff must complete the State's online application assistance training before beginning any application assistance activity.*

III. Customer Service, section C, Cultural and Linguistic Services, paragraph 2.a

- 2.a. *Adds a requirement that the language materials are to be translated into the subscribers' preferred written language, as defined, based on the Contractor's enrollment data as of December 1 of each year only after the State provides this information.*

IV. Customer Service, section A, Covered and Excluded Benefits, paragraph 1

1. *Clarifies that except as required by any provision of applicable law, the benefits described in Program regulations shall be covered benefits under the terms of the Agreement.*

V. Clinical Quality Measures and Management Practices, section A, Measuring Clinical Quality, paragraphs 1 and 2

1. *Clarifies the requirement that performance measures are to be taken from the most recent version of the Healthcare Effectiveness Data and Information Set (HEDIS®); and deletes the requirement that the measures include the number of newly enrolled subscribers receiving an assessment within the first 120 days, or 12 months, immediately preceding the effective date of coverage.*
2. *Clarifies that the report referred to in V.A.1 shall be submitted to the State by June 15 of each year.*

V. Clinical Quality Measures and Management Practices, section B, Measuring Consumer Satisfaction, paragraph 1

1. *Clarifies that the State will conduct an annual consumer satisfaction survey of program participants using the most recent release of NCQA's version of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey; and adds that the State intends to conduct an annual adolescent survey using the Young Adult Health Care Survey (YAHCS).*

V. Clinical Quality Measures and Management Practices, section D, Quality Management Processes, paragraphs 3 and 4

3. *Adds a reference to performance measures listed in item V.B.1; changes comparison of Contractor's performance from over "two reporting periods" to "over time."*
4. *Clarifies that Contractors shall be given the opportunity to participate in pay-for-performance work groups and eliminates the restriction that this opportunity was only for the 2005-06 contract year.*

EXHIBIT B

II. Fiscal Control Provisions, section A, Minimum Loss Ratio, paragraph 2

2. *Adds a requirement for an interim loss ratio for July through November of the current year.*

II. Fiscal Control Provisions, section C, Availability of Federal Funds, paragraphs 1, 2, and 3

1. *Clarifies that agreement is written “based on then-existing regulations and federal executive agencies’ interpretation and application of relevant statutes but before ascertaining” the availability of Congressional appropriation of funds in order to avoid program and fiscal delay.*
2. *Clarifies that Agreement is subject at any additional restrictions, limitations, or conditions “made applicable at any time by:*
 - a. *enactments of Congress*
 - b. *regulations promulgated or amended by federal or executive agencies, or*
 - c. *the interpretation or application by federal executive agencies of relevant regulations and statutes.”*
3. *Clarifies that if sufficient funds are not appropriated or the provisions as described in Exhibit B, Items II.2.a, b and c, affect the provisions, terms or funding of the Agreement, that the Agreement shall be amended to reflect these changes.*

Attachment I Plan Coverage Area Instructions – updated for 2008-09 submission

Attachment II Provider Data File – updated with HIPPA requirements

Attachment III Performance Measures - updated for 2008-09 submission

Attachment VII Plan Fact Sheet – updated for 2008-09 submission

Enclosure 1 Frequently Asked Questions Chart and
Language Grid Changes - updated for 2008-09 submission

Enclosure 2 Evidence of Coverage Instructions - updated for 2008-09 submission

Enclosure 5 Cultural and Linguistic Survey - updated for 2008-09 submission

Enclosure 8 Rate Development Template - updated for 2008-09 submission

Infant Rate Development Template - updated for 2008-09 submission

EVIDENCE OF COVERAGE, PLAN DESCRIPTIONS, FREQUENTLY ASKED QUESTIONS (FAQ) CHART, AND LANGUAGE GRID CHANGES

Indicate any changes to your current (2007-08) EOC/COI by submitting **only** the pages with changes indicated on them, **not** your entire EOC/COI. When submitting the changes, include the entire page that will be changed so we can review the change in context. Use ~~strikethrough~~ for text you are deleting and underline text you are adding.

Additionally, provide a separate document summarizing the changes your plan is proposing, including the page number and an explanation for each change.

A customized plan document package including the Plan Description, Frequently Asked Questions Chart, and Language Grid will be emailed to each plan by October 31, 2007. Instructions for changes to these documents can be found in Enclosure 1 in the 2008-09 Contract Amendment Package.

GEOGRAPHIC GRIDS AND ZIP CODE CHANGES

Please submit Geographic Area Grids and Partial County Coverage Areas for the 2008-09 benefit year electronically via a customized Plan Coverage Area Workbook, entitled "Attachment 1, Plan Coverage.xls." The customized Plan Coverage Area Workbook clearly identifies your current coverage area and allows for the identification of proposed coverage areas in both partial and full counties for the 2008-09 benefit year. A customized Plan Coverage Area Workbook for 2008-09 will be e-mailed to each plan separately and contains instructions on how to complete the workbook.

Note: MRMIB must receive confirmation that you have obtained regulatory approval for any expansion areas. Confirmation of your regulatory approval from DMHC should be sent via email to HFPCContract08@mrmib.ca.gov no later than March 14, 2008. If your regulatory approval for expansion areas is not received by MRMIB by March 14, 2008, MRMIB reserves the right, at its sole discretion, to not include the expanded coverage areas in your 2008-09 contract amendment.

DEADLINES

By **December 7, 2007**, email to HFPCContract08@mrmib.ca.gov the following documents:

- Plan Coverage Workbook
- Updated Evidence of Coverage/Certificate of Insurance
- Plan Fact Sheet
- Plan Description
- Language Grid
- Frequently Asked Questions Chart

By **December 11, 2007** please submit one paper copy of the Comparative Chart and all requested documents (except the rate development template) filed in a three-ring binder to:

Denise M. Arend, Chief Deputy Director
Managed Risk Medical Insurance Board
1000 G Street, Suite 450

Sacramento, CA 95814

By **January 7, 2008**, email your completed schedules in the Rate Development Template to HFPRates08@mrmib.ca.gov.

By **January 9, 2008**, mail a signed Actuarial Certification (Schedule 11 for ALL health plans, Schedule 6 for health plans with AIM babies, and Schedule 10 for dental and vision plans) to:

Jackie Baker, Financial Operations Officer
Managed Risk Medical Insurance Board
1000 G Street, Suite 450
Sacramento, CA 95814

If you have any questions, please call me at (916) 324-4695 or e-mail me at darend@mrmib.ca.gov.

Enclosures

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EXHIBIT A SCOPE OF WORK

I. INTRODUCTION

A. Act and Regulation

This Agreement is in accord with and pursuant to Section 12693 et. seq., Part 6.2 of Division 2 of the California Insurance Code, which establishes the Healthy Families Program (hereinafter the Program). The Agreement is also in accord and pursuant to Title XXI of the Social Security Act and its implementing federal regulations, which establish the State Children's Health Insurance Program and provide authorization and federal funding for the Healthy Families Program, and Title 10, Chapter 5.8 of the California Code of Regulations (hereinafter Program Regulations). Terms and conditions used in the Program Regulations shall have the same and identical meanings in this Agreement.

B. Health Care Service Plan (HMO)

This Agreement is entered into by the Contractor and the State for the purpose of providing health coverage for subscribers determined to be eligible by the State. The method of delivery of the insured health benefits shall be a health maintenance organization. The Contractor agrees to provide and maintain the health maintenance organization.

OR

B. Exclusive Provider Organization (EPO)

This Agreement is entered into by the Contractor and the State for the purpose of providing health coverage for subscribers determined to be eligible by the State. The method of delivery of the insured health benefits shall be an exclusive provider organization. The Contractor agrees to provide and maintain the exclusive provider organization.

C. Geographic Areas Covered

1. The Contractor's participation in the Program is limited to enrollment of Program subscribers who reside in the Contractor's licensed service area accepted by the State. These geographic areas are described in Attachment I: Geographic Area Grid.
2. Geographic coverage in the Program may be changed only upon written approval by the State. The Contractor shall request such approval in writing at least sixty (60) days prior to the date the

change will take place and shall include documentation from the state licensing agency that approved the changes to the Contractor's licensed service area.

3. If the change requested is to withdraw from an area due to a plan-initiated licensure change or removal, the State shall cease new enrollment of subscribers in the area and the Contractor shall continue to maintain and provide services to subscribers in the area until the end of the benefit year.
4. If the change requested is to withdraw from an area due to a plan-initiated licensure change or removal for a date that is not concurrent with the Program's open enrollment, then the Program will hold a special open enrollment pursuant to Exhibit B, Item I.C.

D. Changing Health Care Providers

1. The Contractor's organization shall consist of the list of health care providers to be provided to the State. These providers (institutional and professional) are listed in the Contractor's Provider Directory. The Contractor agrees to provide copies of the Provider Directory to the State upon request, and to annotate, on a quarterly basis, the information required in Item II.K. with a notation that indicates the providers that are accepting or not accepting new Program subscribers.
2. Health care providers shall be deemed added to or deleted from the Contractor's Provider Directory as contracts between the Contractor and health care providers begin or end. If such contract activity either opens a new zip code to the coverage contemplated by this Agreement or would materially impair the Contractor's capacity to perform under this Agreement, the Contractor shall, **at the time of submission to the state licensing agency, provide a copy of the documentation referenced in Section I.C.2, shall** give not less than sixty (60) days written notice to the State and shall implement the change only upon written approval by the State.
3. In addition to any other rights the subscriber may have under existing law **including paying providers fee-for-service in conformance with Health & Safety Code section 1373.96(d)(2),** at the State's option, and in consultation with the Contractor, the Contractor agrees to maintain the availability of those providers listed at any time during the benefit year in the Contractor's Provider Directory until the end of the benefit year, if elimination of the provider would impact twenty-five (25) or more subscribers

enrolled with the Contractor through the Program. For the purpose of this section, the term “provider” may refer to a solo practitioner, a medical group or a clinic.

4. Item I.D.3. above shall not apply if the withdrawal of a provider from the Contractor’s network was done at the request of the provider or is part of the Contractor’s activities to obtain or retain National Committee for Quality Assurance/Joint Commission on the Accreditation of Healthcare Organizations (NCQA/JCAHO) accreditation, or is initiated by the Contractor for cause.

E. Term of Agreement

The term of this Agreement shall be from July 1, 2005 through June 30, 2008. At its sole discretion, the State may exercise the option to negotiate an Agreement for two subsequent one-year terms. The State shall exercise this option no later than sixty (60) days prior to the expiration date of this Agreement. Such extension shall be by an amendment to this Agreement. Reimbursement rates applicable to each subsequent one-year term shall be negotiated by the parties and included in the amendment. Renewal of the Agreement is contingent upon successful performance by the Contractor, as determined by the State at its sole discretion.

II. ENROLLMENT

A. Eligibility

1. All subscribers who are determined eligible by the State in accordance with the Act and Program regulations are eligible to enroll in a program health plan. The State certifies that its enrollment process will not be prejudicial to the Contractor or other participating health plans. **The Contractor agrees that the State conducts all eligibility determinations and shall not attempt to conduct its own eligibility investigations or inquiries.**
2. Upon notification, in writing and electronically when appropriate, by the State, the Contractor agrees to serve subscriber parents in the Program. Rates and other contractual terms shall be negotiated between the Contractor and the State prior to implementation and shall be implemented through an amendment to this Agreement.

B. Enrollment of Infants Born to Women Enrolled in the Access for Infants and Mothers (AIM) Program (only for health plans that are also AIM contractors)

1. The Contractor shall notify any woman enrolled in the AIM program with the Contractor that her newborn will be eligible for automatic enrollment in the Healthy Families Program from birth, provided the State receives the information and required family child contribution specified in the Program regulations by the end of the eleventh month following the month of birth.
2. Within five calendar days of the Contractor's being notified of the birth of an infant born to a woman enrolled in the AIM Program with the Contractor, the Contractor shall provide the State with the following information: infant's name, infant's date of birth, infant's address, infant's gender, mother's name and identification number, infant's birth weight, and, if known, infant's primary care provider. This information shall be provided in a manner and format to be specified by the State.
3. If an infant is in need of immediate health care services and the Contractor has knowledge of this need at any time up to 5:00 p.m. on the tenth day of the second full calendar month of the infant's life, the Contractor shall notify the State of the infant's need for services in accordance with the requirements of Article 2, Section 2699.6608, subsection (f) of the Program regulations, and shall provide the information specified in Section 2699.6608, subsection (a) within the time frame specified in Section 2699.6608, subsection (f).

C. Conditions of Enrollment

1. The Contractor agrees to enroll all subscribers referred by the State, in writing and electronically when appropriate, on the date specified by the State.
2. The State shall notify the applicant of enrollment with the Contractor and the effective date of coverage by the Contractor. Except for infants born to women enrolled in the AIM Program with the Contractor and as specified in Item II.C.3., the State shall notify the Contractor of new enrollees no later than ten (10) days prior to the subscriber's effective date of coverage.
3. The Contractor agrees that in special circumstances the State may provide less than ten days' notice prior to a subscriber's effective date of coverage. Special circumstances shall be at the discretion of the State, but Contractor shall be notified of the special circumstance, in writing and electronically when appropriate.

D. Disenrollment

1. The Contractor agrees to disenroll subscribers when notified, in writing and electronically when appropriate, to do so by the State on the date specified by the State.
2. In no event shall any individual subscriber be entitled to the payment of any benefits with respect to health care services rendered, supplies or drugs received or expense incurred following termination of coverage consistent with state and federal law. For the purposes of this Agreement, a charge shall be considered incurred on the date the service or supply giving rise to the charge is rendered or received.

E. Commencement of Coverage

Coverage shall commence for a subscriber at 12:01 a.m. on the day designated by the State as the effective date of coverage.

F. Identification Cards, Provider Directory, and Evidence of Coverage Booklet

1. Except for infants born to women enrolled with the Contractor in the AIM Program and subscribers enrolled with less than ten days' notice pursuant to Item II.C.3., the Contractor shall, no later than the effective date of coverage, issue to applicants on behalf of subscribers an Identification Card, issue or offer a Provider Directory, and issue an Evidence of Coverage booklet setting forth a statement of the services and benefits to which the subscriber is entitled. The Contractor agrees that the materials sent to applicants on behalf of subscribers shall also include information to subscribers regarding how to access services. The information shall be in addition to the description provided in the Evidence of Coverage booklet. Examples of acceptable forms of information include but are not limited to: a brochure on How to Access Services, inclusion in a cover letter of the specific pages in the Evidence of Coverage booklet relating to accessing services, or a magnet listing the telephone number to call to schedule an appointment with a provider. The contractor's Evidence of Coverage booklet, as approved by the State, is hereby incorporated by reference, as fully set forth within.
2. For infants born to women enrolled in the AIM Program with the Contractor and subscribers enrolled with less than ten days' notice pursuant to Item II.C.3., the Contractor shall provide the Identification Card, issue or offer a Provider Directory, and provide

an Evidence of Coverage booklet and other materials described in Item II.F.1. to applicants on behalf of subscribers no later than ten (10) days from the date the Contractor is notified of the enrollment.

3.
 - a. In addition to the instances described in Items II.F.1. through II.F.2., above, the Contractor shall, by April 1 of each year, issue or offer to each applicant on behalf of the subscribers enrolled in the Contractor's plan an updated Provider Directory, and issue either an updated Evidence of Coverage booklet (or amended pages) setting forth a statement of the services and benefits to which the subscriber is entitled in the next benefit year, or a letter describing any changes to the benefits package that will go into effect at the beginning of the next benefit year.
 - b. In any year in which an updated Evidence of Coverage booklet (or amended pages) is not issued by April 1, the Contractor shall issue an updated Evidence of Coverage booklet by June 15 to each applicant on behalf of the subscribers enrolled in the Contractor's plan.
 - c. The Contractor shall obtain written approval by the State prior to issuing the updated Evidence of Coverage booklet (or amended pages) and the letter describing changes in the benefit package. The letter shall be submitted to the State by March 1 for review and approval.
 - d. By July 1 of each year, the Contractor shall submit to the State three two print copies of the updated Evidence of Coverage booklet (or amended pages), one electronic copy of the final approved Evidence of Coverage booklet (or amended pages) on compact disk, and one print copy of the updated Provider Directory.
4. The Contractor's Provider Directory shall be updated and distributed by the Contractor to applicants on behalf of subscribers whenever there is a material change in the Contractor's provider network.
5. The Contractor's Provider Directory shall indicate the language capabilities of the providers.
6. The Contractor shall provide a copy of the Contractor's Evidence of Coverage booklet or a Provider Directory to any person requesting such materials, by telephone or in writing, within ten (10) days of the request.

7. Written informing material provided to subscribers shall be at a sixth grade reading level or at a level that the Contractor determines is appropriate for its subscribers and that is approved by the State, to the extent that compliance with this provision does not conflict with regulatory agency directives or other legal requirements.

G. Primary Care Physician Assignment (HMOs only)

1. The State shall provide the Contractor with the name of each subscriber's chosen primary care physician, if the name of the primary care provider is listed on the Program application. The Contractor agrees to ensure that all subscribers shall be enrolled with a primary care physician within thirty (30) days of the effective date of coverage in the plan, unless the effective day is after the 15th of the month, then it shall be within forty-five (45) days. If the Contractor assigns a primary care physician to a subscriber, the Contractor shall use a fair and equitable method of assignment from the Contractor's physician network and shall promptly notify the subscriber of the selection and the opportunity to change the assigned primary care physician. Such method of assignment shall take into account the geographic accessibility and language capabilities of providers. The Contractor also agrees to notify the primary care physician promptly that he or she has been chosen by the subscriber or assigned by the Contractor.
2. Whenever the Contractor assigns a subscriber to a clinic, the Contractor shall notify the subscriber of his or her right to select a new primary care provider. If a subscriber selects a primary care provider who is affiliated with a clinic and the assignment of the subscriber is made to the clinic pursuant to Insurance Code Section 12693.515, the Contractor shall inform the subscriber that he or she has been assigned to the clinic and has a right to select a new primary care provider immediately or at any future time, including such time as the selected primary care provider is no longer affiliated with the clinic. The Contractor shall notify the subscriber of his or her rights immediately after the assignment to the clinic has been made.

H. Right to Services

Possession of the Contractor's Identification Card confers no right to services or other benefits of the Program. To be entitled to services or benefits, the holder of the card must, in fact, be a subscriber enrolled in the Program.

I. Open Enrollment

The Contractor agrees to participate in an annual open enrollment process during which subscribers may transfer between health plans.

J. Enrollment Data

The State and the Contractor agree to the following regarding the transmission, receipt, and maintenance of enrollment data.

1. The State shall transmit subscriber enrollment and disenrollment information, subscriber data updates, as well as transfer and reinstatement information, to the Contractor using Electronic Data Interchange (EDI) each business day. The Contractor must accept this information via EDI and update its enrollment system within 3 calendar days, excluding holidays. The Contractor shall receive the transmitted information, data and file sent through the EDI in a manner and format that comply with HIPAA standards for electronic transactions and code sets. **The Contractor agrees that the State is the official record holder of subscribers' information and shall not make any changes to Contractor's copy of subscribers' records unless such changes are transmitted by the State.**
2. The Contractor agrees to accept written confirmation of enrollments from the State plan liaisons, in the event system errors cause enrollment transactions to be delayed. The State agrees that the written confirmations are valid and acceptable alternative notifications to the Contractor until the failed or delayed enrollment transaction can be generated and sent to the Contractor.
3. The State shall develop an electronic bulletin board system, available 24 hours a day, excluding maintenance periods that usually will be held on Sundays, to provide the Contractor with enrollment reports.
4. The State shall establish and manage a plan liaison function for the purpose of enhancing the program operations through the sharing and coordination of information with the Contractor. Common or persistent problems or issues with the Contractor shall be communicated to the State. The State shall provide a separate telephone number for communication between the State and the Contractor.

5. The State shall transmit to the Contractor on a weekly basis (on Saturday or Sunday) a separate confirmation file. This shall consist of a record count of the different record types in the weekly enrollment file. The State shall also transmit to the Contractor enrollment and data files on a weekly basis (on Saturday or Sunday) reflecting the prior week's activity. The Contractor shall use the data files to reconcile and validate weekly activity.
6. The State shall complete weekly transmissions by 4:00 a.m. Pacific Standard Time each Monday or, when Monday is an official State holiday, by 4:00 a.m. Pacific Standard Time Tuesday. If the weekly transmission is not completed by the stated time, the State shall promptly notify the Contractor of the date and time when the transmission will be completed.
7. On a monthly basis, the State shall provide audit files for the Contractor, including, but not limited to, currently active subscribers. The audit files shall normally be provided by the third Monday of the month following the month for which data are being reported. If unexpected circumstances cause a delay in the provision of the audit files, the State, through the administrative vendor's assigned plan liaison, shall notify the Contractor.
8. The Contractor agrees to reconcile its enrollment data using the monthly data files sent by the State and the Online Eligibility Verification System (OEVS) provided by the State's administrative vendor. The Contractor shall report any enrollment discrepancies to the State, in a format approved by the State, within sixty (60) days from the date the monthly audit file is provided to the Contractor. The State shall not be liable for any discrepancies reported by the Contractor after this 60-day period. The State shall respond to discrepancies timely submitted to the state by the Contractor.
9. The State shall transmit the files described in Items II.J.1., II.J.5., and II.J.7. to the Contractor at no charge.
10. The State shall provide, at the Contractor's request, retransmission files of the data files set forth in Items II.J.5. and II.J.7. above within six months of the original transmissions. The Contractor agrees to pay for assembly and transmissions costs of the files in Items II.J.5. and II.J.7. above at the rate of \$85 per hour or \$250 per report or file, whichever cost is greater. The State shall waive the assembly and retransmission fee if the State determines that the original transmission file was corrupted or unusable.

11. With respect to Items II.J.5. and II.J.7. above, the Contractor shall utilize the State's plan liaison personnel as much as possible. There shall be no charge for the services of the State's plan liaison.
12. Prior to commencing work requested by the Contractor under Item II.J.10., the State shall provide a cost estimate to the Contractor.
13. The State shall provide EDI instructions and data mapping formats to the Contractor upon request of the Contractor. The State shall provide additional technical assistance, either by telephone or at the Contractor's site, to plans new to EDI data transmission as they establish electronic capability.
14. The State shall conduct at least one meeting for the period of this Agreement for the purpose of providing training and technical assistance to the Contractor regarding EDI and transmission of enrollment data.
15. The Contractor agrees either to use the Program's unique Family Member Number (FMN) in its data base for subscriber tracking purposes or to maintain a cross reference mechanism between the Contractor's unique identifier and the Program's unique identifier.

K. Network Information Service

1. The Contractor agrees to provide, to the best of the Contractor's ability, complete and accurate data on its provider network in an electronic format to be determined by the State. The Contractor understands that the minimum data set requested by the State shall include the information on the Contractor's network outlined in Attachment II, Provider Data File Requirements. The information described in Attachment II may be expanded by the State with no less than ninety (90) days notice by the State. The Contractor agrees to provide additional data elements, as requested by the State, to the best of its ability. The Contractor understands that the State intends to use information provided pursuant to this section to assist potential and current applicants and subscribers in selecting a health plan, and that information provided to the State will be shared with the public.
2. The Contractor agrees to provide the provider network information listed in Attachment II to the State on a quarterly basis, including updated notations on providers accepting or not accepting new Program subscribers. The Contractor may update its provider network information on a monthly basis. The Contractor is required

to provide data for the creation of the database to the State between the 11th and 25th of any submission month.

3. If the Contractor is unable to provide electronic files in the specified provider network formats, the State agrees to offer the Contractor data capture services at the rate of \$25 per hour.
4. If the Contractor so requests, the State agrees to offer the Contractor an unscheduled update to the provider network information at the rate of \$500 per update.

L. Traditional and Safety Net Providers

1. The Contractor agrees to establish, with traditional and safety net providers as described in Article 4 of the Program regulations, network membership and payment policies which are no less favorable than its policies with other providers.
2. The Contractor shall, on or before April 30 of each year, report to the State on the number of subscribers who selected traditional and safety net providers as the subscriber's primary care physician in the previous year. The format for the report shall be determined by the State.
3. No later than January 15 of each year, the Contractor shall provide the State with a list of those traditional and safety net providers (as described in Article 4 of the Program regulations) that have signed contracts with the Contractor to provide services to Program subscribers.
4. The Contractor assures the State that it has signed contracts with all providers the Contractor has listed in its Traditional and Safety Net Provider Report described in Item II.L.3. above, and shall provide the State with copies of the contracts, if requested by the State.

M. Public Awareness

1. The Contractor agrees to engage in marketing efforts designed to increase public awareness of and enrollment in the Program. At a minimum these efforts shall include the following activities. The Contractor shall publicize its participation in the Program through its internal provider communications and through its general membership communication publications. All public awareness efforts must be approved by the State before being released in public and must be in compliance with the requirements of the

Knox-Keene Health Care Service Plan Act of 1975, including amendments and applicable regulations. In the event that the State does not notify the Contractor in writing, with the reasons the marketing materials are not approved, within sixty (60) days of receipt by the State, the materials shall be deemed approved.

2. The Contractor is prohibited from directly, indirectly, or through its agents, conducting in person, door to door, mail or telephone solicitation of applicants for enrollment.
3.
 - a. By September 1, 2005, the Contractor agrees to submit to the State for its approval, in a format determined by the State, a marketing plan that covers the term of this Agreement.
 - b. The marketing plan shall include the Contractor's mission statement, a written description of proposed marketing activities and locations, a listing of all proposed marketing materials to be used, and proposed locations for distribution, including ancillary components such as scripts. Upon request by the State, the Contractor shall submit other information, such as examples of previously approved marketing materials currently being used.
 - c. The marketing plan shall be in compliance with all applicable statutes and regulations, as well as the Program's marketing guidelines.
4. For the 2006-07 and 2007-08 benefit years, the Contractor agrees to submit to the State for its approval, in a format determined by the State, any proposed updates or amendments to its then-approved marketing plan.
5. If the Contractor chooses to provide application assistance, the plan must have an approved application assistance plan on file with the State **and agrees that its designated staff must successfully complete the State's online application assistance training before beginning any application assistance activity.**

III. CUSTOMER SERVICE

A. Telephone Service for Subscribers

The Contractor agrees to provide a toll free telephone number for applicant and subscriber inquiries. This telephone service shall be available on regular business days from the hours of 8:30 a.m. to 5:00

p.m. Pacific Standard Time. The Contractor shall provide staff bilingual in English and Spanish during all hours of telephone service. The Contractor shall have the capability to provide telephone services via an interpretive service for all limited English proficient (LEP) persons.

B. Grievance Procedure (DMHC)

Department of Managed Health Care Licensees:

1. The Contractor shall establish a grievance procedure to resolve issues arising between itself and subscribers or applicants acting on behalf of subscribers. The Contractor's process shall provide a written response to subscriber grievances and resolution of subscriber grievances as required by Contractor's licensing statute, the Knox-Keene Health Care Service Plan Act of 1975, as amended. These procedures shall be described in the Contractor's Evidence of Coverage booklet.
2. The Contractor shall report to the State by February 1 of each year, in a format determined by the State, the number and types of benefit grievances filed by subscribers and by applicants on behalf of subscribers in the previous calendar year in the Program. Benefit grievances include, but are not limited to, complaints about waiting time for appointments, timely assignment to a provider, issues related to cultural or linguistic sensitivity, difficulty with accessing specialists and the administration and delivery of medical benefits in the Program.

OR

B. Grievance Procedure (DOI)

Department of Insurance Licensees:

1. The Contractor shall establish a grievance procedure to resolve issues arising between itself and subscribers or applicants acting on behalf of subscribers. The Contractor's process shall include all features required for health care service plans pursuant to the Knox-Keene Health Care Service Plan Act of 1975, as amended, and shall provide a written response to subscriber grievances and resolution of subscriber grievances as required by the Knox-Keene Act. These procedures shall be described in the Contractor's Certificate of Insurance booklet.
2. The Contractor shall report to the State by February 1 of each year, in a format determined by the State, the number and types of

benefit grievances filed by subscribers and by applicants on behalf of subscribers in the previous calendar year in the Program. Benefit grievances include, but are not limited to, complaints about waiting time for appointments, timely assignment to a provider, issues related to cultural or linguistic sensitivity, difficulty with accessing specialists and the administration and delivery of medical benefits in the Program.

C. Cultural and Linguistic Services

1. Linguistic Services

- a. The Contractor shall ensure compliance with Title 6 of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, and 45 C.F.R. Part 80) which prohibits recipients of federal financial assistance from discriminating against persons based on race, color or national origin. This is interpreted to mean that a limited English proficient (LEP) individual is entitled to equal access and participation in federally funded programs through the provision of bilingual services.
- b. The Contractor shall provide twenty-four (24) hour access to interpreter services for all (LEP) subscribers seeking health services within the Contractor's network. The Contractor shall use face-to-face interpreter services, if feasible. If face-to-face interpreter services are not feasible, the Contractor may use telephone language lines for interpreter services. The Contractor shall develop and implement policies and procedures for ensuring access to interpreter services for all LEP subscribers, including, but not limited to, assessing the cultural and linguistic needs of its subscribers, training of staff on the policies and procedures, and monitoring its language assistance program. The Contractor's procedures must include ensuring compliance of any subcontracted providers with these requirements. Activities that the Contractor may undertake to assure compliance of subcontracted providers include, but are not limited to, employing competent bilingual or multilingual staff who can interpret for providers and subscribers, and using competent contracted community-based organizations for interpreter services.
- c. When the need for an interpreter has been identified by the provider, or requested by a subscriber the Contractor agrees to provide a competent interpreter for scheduled appointments. The Contractor shall avoid unreasonable

delays in the delivery of health care services to persons of limited English proficiency. The Contractor shall instruct the providers within its health maintenance organization network to record the language needs of subscribers in the medical record.

- d. The Contractor agrees that subscribers shall not be required to or encouraged to utilize family members or friends as interpreters. After being informed of his or her right to use free interpreter services provided by the Contractor, a subscriber may use an alternative interpreter of his or her choice at his or her cost. The Contractor shall encourage the use of qualified interpreters. The Contractor agrees that minors shall not be used as interpreters except for only the most extraordinary circumstances, such as medical emergencies. The Contractor shall ensure that the request or refusal of language or interpreter services is documented in the medical records of providers in the Contractor's health maintenance organization network. Activities that the Contractor may undertake to ensure compliance of providers with this paragraph include, but are not limited to, training its providers on the need to document a request or refusal of interpreter services; supplying providers and their staff with Request/Refusal forms for interpreter services ; supply providers and their staff with chart labels identifying member language needs; implementing an incentive program to reward provider offices that affirmatively attempt to identify language needs of LEP members and record them on the medical charts; conducting reviews of providers' medical records during periodic audits and/or facility site reviews to check for documentation of the request for or refusal of interpreter services; and providing other technical assistance to providers.
- e. The Contractor shall inform subscribers of the availability of linguistic services. Information provided to subscribers regarding interpreter services shall include but not be limited to: the availability of interpreter services to subscribers at no charge; the right not to use family members or friends as interpreters; the right to request an interpreter, during discussions of medical information such as diagnoses of medical conditions and proposed treatment options, and explanations of plans of care or other discussions with providers; the right to receive subscriber materials as described in Item III.C.2. of this Exhibit; and the right to file a complaint or grievance if linguistic needs are not met.

- f. The Contractor shall ensure that there is appropriate bilingual proficiency at medical and non-medical points of contact for providers who list their bilingual capabilities in provider directories. Medical points of contact include advice and urgent care telephone lines and face-to-face encounters with providers who provide medical or health care advice to members. Non-medical points of contact include member/customer service, plan or provider office reception, appointment services, and member orientation sessions. Activities that the Contractor may undertake to ensure the bilingual proficiency of interpreters at medical and non-medical points of contact include, but are not limited to: hiring staff who demonstrate conversational fluency as well as fluency in medical terminology; providing training that will enable staff to take, or assist with gathering, information for an accurate medical history with culturally related consent forms; providing dictionaries and glossaries for interpreters; providing provider staff with consistent interpreter training by experienced and properly trained interpreters; periodically assessing the language proficiency of the plan's identified medical and non-medical staff who have patient contact; conducting audits of provider sites to confirm ongoing language capabilities of providers and staff; and providing other technical assistance to providers.
- g. The Contractor shall identify and report the on-site linguistic capability of providers and provider office staff through the reporting required for the Network Information Service described in Item II.K. of this Exhibit.
- h. If the State finds that the Contractor is deficient in meeting the Cultural and Linguistic requirements specified in Section C, Cultural and Linguistic Services, the Contractor shall submit a corrective action plan that corrects the deficiency within a time period satisfactory to the State.

2. Translation of Written Materials

- a. The Contractor agrees to translate written informing materials for subscribers including, but not limited to, the Evidence of Coverage booklet; form letters; notice of action letters; consent forms; letters containing important information regarding participation in the health plan; notices pertaining to the reduction, denial, modification, or termination of services; notices of the right to appeal such

actions or that require a response from subscribers; notices advising LEP subscribers of the availability of free language assistance services; other outreach materials; and medical care reminders. Written informing materials for subscribers shall be provided at a sixth grade reading level or as determined appropriate through the Contractor's Cultural and Linguistic Needs Assessment and approved by the State, to the extent that compliance with this requirement does not conflict with regulatory agency directives or other legal requirements. Translation of these materials shall be in the following languages: Spanish, and any language representing the preferred mode of communication for the lesser of either five percent (5%) or more of the Contractor's enrollment or 3,000 or more subscribers of the Contractor's enrollment in the Program as of December 1 of the previous year. In addition, if the State includes the subscriber's preferred written language in the enrollment file sent to the Contractor, and that language is Spanish or the preferred mode of communication for either five percent (5%) or more of the Contractor's enrollment or 3,000 or more subscribers of the Contractor's enrollment in the Program, Contractor shall provide materials in that language. If the Contractor serves both Medi-Cal and Program subscribers, it is encouraged, where practicable, to translate Program member materials into additional Medi-Cal threshold languages not required by the Program. The Contractor shall ensure that members who are unable to read the written materials that have been translated into non-English languages have an alternate form of access to the contents of the written materials. Activities that the Contractor may undertake to comply with this paragraph include, but are not limited to, informing LEP subscribers, during the welcome call, of the plan's language assistance services; encouraging members to call the Contractor if they need help in understanding any of the Contractor's written materials; providing an oral translation of the material in a member's preferred language or arranging for this to be done by a competent interpreter service; and making the content of the written materials available in alternative formats such as Braille, CD, and audio cassette.

- b. The Contractor shall ensure the quality of the translated material. The Contractor is encouraged to use different qualified translators during sequential levels of the translation process to ensure accuracy, completeness and

reliability of translated materials. The Contractor agrees that the translation process shall include the use of qualified translators for translating and editing, proofreading and professional review. Activities that the Contractor may undertake to ensure the quality of translated materials include, but are not limited to, contracting and using certified translation companies that follow a step-by-step translation process; performing back translation of material into its source language for comparison and accuracy by certified translation vendors other than the original translator; having an internal team review committee that includes a medical and/or legal “professional reviewer” who reviews translated materials for cultural appropriateness; and proof-reading and editing of the document by a separate qualified translation editor/proof reader. The Contractor may use computer technology as part of the process for producing culturally and linguistically appropriate translation. Guidelines for developing and producing culturally and linguistically appropriate translations and definitions for the terms used are included in Attachment IV, Translated Process Flowchart.

- c. By September 30 of each year, the Contractor shall submit to the State one copy of only those materials that, pursuant to Item II.E., are routinely provided to new subscribers for each language in which the materials are translated.

3. Cultural and Linguistic Group Needs Assessment

- a. By June 30, 2007, the Contractor agrees to conduct and submit to the State a Cultural and Linguistic Needs Assessment to promote the provision and utilization of appropriate services for its diverse enrollee population. The Needs Assessment report shall include findings from the assessment described in Item III.C.3.b. below and a plan outlining the proposed services to be improved or implemented as a result of the assessment findings, with special attention to addressing cultural and linguistic barriers and reducing racial, ethnic, and language disparities.
- b. The Cultural and Linguistic Needs Assessment shall examine the demographic profile of the Contractor’s Program enrollees by ethnicity and language to assess their linguistic and cultural needs. The assessment shall be conducted in accordance with guidelines issued by the State and shall examine the language preference of the Program

enrollees and other data, including, but not limited to, the health risks, beliefs, and practices of the Contractor's enrollees. The Contractor may conduct the Needs Assessment individually or collaboratively with other plans participating in the Program.

- c. The Contractor shall assess the internal systems it has in place to address the cultural and linguistic needs of its Program enrollment population, including, but not limited to, assessing the Contractor's capacity to provide linguistically appropriate services. The Contractor shall review internal data including complaints and grievances, results from member surveys, diversity and language ability of staff as reflective of the enrollee population, internal policies and procedures, education and training of staff and providers regarding cultural and linguistic competency issues, and, to the extent feasible, utilization and outcome data analyzed by race, ethnicity and primary language. This information shall be examined in relation to and compared with external data for benchmarking and trends.
- d. The Contractor agrees to provide an opportunity for representatives of subscribers enrolled in the Program to provide input on the Cultural and Linguistic Needs Assessment. The Contractor may use an existing member advisory committee or community advisory committee for the purposes of providing an opportunity for Program subscribers to provide input. The Contractor shall ensure that the committee used to obtain input from subscribers is representative of subscribers in the program and includes representatives from hard-to-reach populations. The Contractor shall also ensure that the committee holds regular meetings and is provided with adequate resources to support committee activities and support staff.

4. Operationalizing Cultural and Linguistic Competency

- a. The Contractor shall develop internal systems that meet the cultural and linguistic needs of the Contractor's subscribers in the Program. The Contractor shall provide initial and continuing training on cultural competency to staff and providers. Ongoing evaluation and feedback on cultural competency training shall include, but not be limited to, feedback from subscriber surveys, staff, providers, and encounter/claims data.

- b. Activities that the Contractor may undertake in developing its internal systems to meet the cultural and linguistic needs of the Contractor's subscribers include: incorporating cultural competency in the Contractor's mission; establishing and maintaining a process to evaluate and determine the need for special initiatives related to cultural competency; developing recruitment and retention initiatives to establish organization-wide staffing that is reflective and/or responsive to the needs of the community; assessing the cultural competence of plan providers on a regular basis; establishing a special office or designated staff to coordinate and facilitate the integration of cultural competency guidelines; providing an array of communication tools to distribute information to staff relating to cultural competency issues (e.g., those tools generally used to distribute other operational policy-related issues); participating with government, community, and educational institutions in matters related to best practices in cultural competency in managed health care to ensure that the Contractor maintains current information and an outside perspective in its policies; maintaining an information system capable of identifying and profiling cultural and linguistic specific patient data; and evaluating the effectiveness of strategies and programs in improving the health status of cultural-defined populations.
- c. The Contractor shall report, on or before December 10 of each year, the linguistically and culturally appropriate services provided and proposed to be provided to meet the needs of limited-English proficient applicants and subscribers in the Program. This report shall address types of services including, but not limited to, linguistically and culturally appropriate providers and clinics available, interpreters, marketing materials, information packets, translated written materials, referrals to culturally and linguistically appropriate community services and programs, and training and education activities for providers. The Contractor shall also report its efforts to evaluate cultural and linguistic services and outcomes of cultural and linguistic activities as part of the Contractor's ongoing quality improvement efforts. Reported information may include member complaints and grievances, results from membership satisfaction surveys, and utilization and other clinical data that may reveal health disparities as a result of cultural and linguistic barriers. The report shall also address activities undertaken by the Contractor to develop internal systems, as described in Item III.C.4.b of this Exhibit. The

Contractor shall also report on the status of the Contractor's cultural and linguistic activities developed from the Needs Assessment. The format for this report shall be determined by the State.

IV. COVERED SERVICES AND BENEFITS

A. Covered and Excluded Benefits

1. Except as required by any provision of applicable law, ~~only those~~ the benefits described in Article 3, Sections 2699.6700 through 2699.6707, of the Program regulations shall be covered benefits under the terms of this Agreement. Except as required by any provision of applicable law, those benefits excluded in Article 3 of the Program regulations shall not be covered benefits. The Contractor shall set out the plan of coverage in an Evidence of Coverage booklet.
2. The parties understand that terms of coverage under this Agreement are set forth in the attached Evidence of Coverage booklet, hereby incorporated by reference, as fully set forth within. In the case of conflicts, terms of coverage set forth in the Evidence of Coverage booklet shall be binding notwithstanding any provisions in this Agreement which are less favorable to the subscriber.
3. The Contractor shall make benefit and coverage determinations. All such determinations shall be subject to the Contractor's grievance procedures.
4. State Supported Services as defined in the program regulations are not covered under this Agreement.

B. California Children's Services (CCS)

1. Medically necessary services that are authorized by the CCS Program to treat a subscriber for CCS eligible conditions, once CCS eligibility is determined as defined in Title 22, CCR, Section 41518, are not covered under this Agreement. The Contractor shall identify subscribers with suspected CCS eligible conditions and shall refer them to the local CCS office for determination of medical eligibility by the CCS Program. Upon referral, the Contractor shall provide the applicant on behalf of the subscriber with a California Children's Services one page (double sided) informational flyer. The State agrees to provide the Contractor with camera-ready copies of the California Children's Services informational flyer.

2. The Contractor shall implement written policies and procedures for identifying and referring subscribers with suspected CCS eligible conditions to the local CCS Program. The policies and procedures shall include, but not be limited to:
 - a. Procedures for ensuring that the Contractor's providers are informed of the identity of CCS paneled providers and CCS approved hospitals within the Contractor's entire network.
 - b. Policies and operational controls that ensure that the Contractor's providers perform appropriate baseline health assessment and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a subscriber has a CCS eligible medical condition.
 - c. Policies and procedures to assure that the Contractor's providers refer potentially eligible children to the CCS Program.
 - d. Procedures that provide for continuity of care between the Contractor's providers and CCS providers.
3. The Contractor shall report to the State the number of subscribers who were referred to the local CCS program. The report is due by July 31 of each year. The format for the report shall be determined by the State.
4. The Contractor shall consult and coordinate CCS referral activities with the local CCS Program in accordance with the required Memorandum of Understanding (MOU) between the Contractor and the local CCS Program.
5. Until eligibility for the CCS Program is established, the Contractor shall continue to be responsible for arranging for the delivery of all covered medically necessary health care and case management services for a subscriber referred to CCS. Services which are provided by a CCS paneled provider or approved facility on the date of referral, or afterwards, and which are authorized by the CCS program for a CCS eligible child, shall be paid by the CCS program at the CCS reimbursement rate retroactively to the provider of services.
6. Once eligibility for the CCS Program is established for a subscriber:
 - a. The Contractor shall continue to provide covered primary care and all other medically necessary covered services

other than those provided through the CCS Program for the CCS eligible condition and shall ensure the coordination of services between its primary care providers, the CCS specialty providers and the local CCS Program.

- b. The CCS Program shall authorize and pay for the delivery of medically necessary health care services to treat a subscriber's CCS eligible condition. The CCS authorization, on determination of medical eligibility, shall be to CCS paneled providers and approved facilities, some of which may also be members of the Contractor's network. Authorization normally cannot predate the initial referral to the local CCS Program in accordance with Title 22, CCR, Section 42180. Claims for authorized services shall be submitted to the appropriate CCS office for approval of payment.
- c. For the purposes of Item IV.B.6.b., above, initial referral means referral by a Contractor network physician, or by any other entity permissible under CCS regulations.

C. Mental Health: Family Members

The Contractor agrees to involve appropriate family members in the mental health and/or substance abuse services provided to a subscriber who has experienced family dysfunction and/or trauma to the extent it is required as a course of treatment for the health and recovery of the child.

D. Mental Health: Services for Subscriber Children with Serious Emotional Disturbance or Serious Mental Disorder

- 1. The Contractor is not responsible for providing or reimbursing a county for services to treat a subscriber child's serious emotional disturbance or serious mental disorder that are provided or authorized by a County Mental Health Department as defined in Welfare and Institutions Code Section 5600.3. The Contractor shall identify subscriber children who potentially have a serious emotional disturbance or serious mental disorder and shall refer them to the County Mental Health Department for determination of medical eligibility. Upon referral, the Contractor shall provide the applicant on behalf of the subscriber child a County Mental Health one-page (double sided) information flyer. The State agrees to provide the Contractor with camera-ready copies of the County Mental Health informational flyer. The Contractor shall assure the State that it will cooperate with the local County Mental Health Department in establishing policies and procedures that will

successfully develop the interface between the Contractor and the local County Mental Health Department.

2. The Contractor shall implement the written policies and procedures it has developed in cooperation with County Mental Health Department Programs for identifying and referring children who potentially have a serious emotional disturbance or serious mental disorder to the County Mental Health Department for determination of medical eligibility. These policies and procedures shall include, but not be limited to:
 - a. Identification of a specific screening process for identifying and referring subscriber children who potentially have a serious emotional disturbance or serious mental disorder. The County Mental Health Department shall make the final determination of whether the subscriber child has a serious emotional disturbance or serious mental disorder. The MOU shall provide specific time frames for the County Mental Health Department to notify the Contractor about the assessment and determination of whether a subscriber child has a serious emotional disturbance or serious mental disorder.
 - b. Procedures to assure that the Contractor and the Contractor's providers have the screening instrument and specific referral protocols to govern referral of subscriber children who potentially have a serious emotional disturbance or serious mental disorder to the County Mental Health Department. These protocols should assure that referral is made at the earliest recognition by the Contractor or the Contractor's providers that the subscriber child may have a serious emotional disturbance or serious mental disorder.
 - c. A procedure to assure that baseline health and mental health information about the subscriber child is shared between the Contractor and the County Mental Health Department and any County Contract Providers.
 - d. Procedures that provide for continuity of care between the Contractor and the Contractor's providers and the County Mental Health Department and any County Contract Providers.
 - e. Procedures that maintain continuity of care for the subscriber child when the subscriber child is a new subscriber child with

the Contractor and has an ongoing treatment plan with the County Mental Health Department. This procedure shall include an automatic referral for a new subscriber child who has a treatment plan for serious emotional disturbance or serious mental disorder with the County Mental Health Department.

- f. Designation of at least one Contractor's employee as Mental Health Services Liaison who shall, as one of his or her primary functions, coordinate and collaborate with each County Mental Health Department in which Contractor serves Program subscribers. The name and contact information of this liaison, including changes, shall be provided to the State in Contractor's annual Fact Sheet submission.
3. The Contractor shall report to the State the number of children who were referred to the County Mental Health Department. The report is due by July 31 of each year. The format for the report shall be determined by the State.
4. Unless and until eligibility for the County Mental Health Department Programs for children with serious emotional disturbance or serious mental disorder is established, the Contractor shall continue to provide all covered medically necessary health care and case management services for a subscriber child referred to the County Mental Health Department.
5. Once eligibility for the County Mental Health Department Program for children with serious emotional disturbance or serious mental disorder is established for a subscriber child:
 - a. The County Mental Health Department will notify the Contractor of the determination, in a time frame consistent with the Memorandum of Understanding.
 - b. The Contractor shall continue to provide all other covered services, including, but not limited to, primary care and any medically necessary covered drugs, laboratory and inpatient care, up to the limit of coverage and consistent with the Contractor's mechanism for subscriber conversion of an inpatient day for other less intensive treatment services, and shall work with the County Mental Health Department to ensure the coordination of services between its primary care providers and the County Mental Health Department and its specialty providers.

- c. The County Mental Health Department will authorize the delivery of medically necessary health care services to treat a subscriber child's serious emotional disturbance or serious mental disorder.
6. Memoranda of Understanding shall include a mediation process to assure that disputes concerning referral or coverage questions, and any other areas of dispute between the Contractor and the County Mental Health Department can be mediated and resolved.
7. Nothing in this section shall be construed to relieve the Contractor of the responsibility to provide mental health care, up to the limits set forth in Article 3 of the Program regulations, for subscriber children who are referred to the County with serious emotional disturbance or serious mental disorder.

E. Other Public Linkages

The Contractor shall, to the extent feasible, create viable protocols for screening and referring subscribers needing supplemental services outside of the scope of benefits described in Article 3 of the Program regulations to public programs providing such supplemental services for which they may be eligible, as well as for coordination of care between the Contractor and the public programs. Public programs may include but not be limited to: regional centers, programs administered by the Department of Alcohol and Drug Programs, Women, Infants and Children Supplemental Food Program (WIC), lead poisoning prevention and programs administered by local education agencies.

F. Pre-existing Condition Coverage Exclusion Prohibition

No pre-existing condition exclusion period or post-enrollment waiting period shall be required of subscribers.

G. Exercise of Cost Control

The Contractor shall enforce all contractual agreements for price and administer all existing utilization control mechanisms for the purpose of containing and reducing costs.

H. Copayments

1. The Contractor shall impose copayments for subscribers as described in Article 3 of the Program regulations. The Contractor agrees that copayment maximums as described in Article 3 of the

Program regulations shall be applied for each benefit year and shall be renewed on July 1 of each year. The Contractor's Evidence of Coverage or Certificate of Insurance document shall describe the process to be used by applicants on behalf of subscribers to document that the annual two hundred and fifty dollar (\$250) out-of-pocket family maximum has been reached.

2. The Contractor shall work with its provider networks to provide for extended payment plans for subscribers utilizing a significant number of health services for which copayments are required. When feasible, the Contractor shall instruct its provider network to offer extended payment plans whenever a family's copayments exceed twenty-five dollars (\$25) in one month.
3. The Contractor shall report the number of subscribers who meet the copayment maximum in the previous benefit year by October 1 of each year. The format for the report shall be determined by the State.
4. The Contractor shall implement an administrative process that ensures that the Contractor waives all copayments for American Indian and Alaska Native subscribers in the Program, if the State identifies such subscribers as qualifying for the waiver.

I. Coordination of Benefits

The Contractor agrees to coordinate benefits with other group health plans or insurance policies for subscribers in the Program. The Contractor agrees to work with other plans or insurers to provide no more than one-hundred percent (100%) of subscribers' covered medical expenses. The Contractor shall coordinate such that coverage provided pursuant to this Agreement is secondary to all other coverage except for Medicaid (Medi-Cal) and Access for Infants and Mothers (AIM).

J. Acts of Third Parties

If a subscriber is injured through the wrongful act or omission of another person, the Contractor shall provide the benefits of this Agreement and the subscriber or applicant on behalf of a subscriber shall be deemed:

1. To have agreed to reimburse the Contractor to the extent of the reasonable value of services allowed by Civil Code Section 3040, immediately upon collection of damages by him or her, whether by action at law, settlement or otherwise, provided that the subscriber is made whole for all other damages resulting from the wrongful act or omission before the Contractor is entitled to reimbursement; and

2. To have provided the Contractor with a lien to the extent of the reasonable value of services provided by the Contractor and allowable under Civil Code Section 3040, provided that the subscriber is made whole for all other damages resulting from the wrongful act or omission before the Contractor is entitled to reimbursement. The lien may be filed with the person whose act caused the injuries, his or her agent, or the court.

K. Workers' Compensation Insurance

If, pursuant to any Workers' Compensation or Employer's Liability Law or other legislation of similar purpose or import, a third party is responsible for all or part of the cost of health services provided by the Contractor, then the Contractor shall provide the benefits of this Agreement and the subscriber shall be deemed to have provided the Contractor with a lien on such Workers' Compensation medical benefits to the extent of the reasonable value of the services provided by the Contractor. The lien may be filed with the responsible third party, his or her agency, or the court. For purposes of this subsection, reasonable value shall be determined to be the usual, customary or reasonable charge for services in the geographic area where the services are rendered.

L. Use of Subcontractors

The Contractor may, in its discretion, use the services of subcontractors to recover on the liens provided for under Items IV.J. and IV.K. of this Exhibit. The subcontractor's compensation may be paid out of any lien recoveries obtained. The State understands and agrees that lien recoveries are chargeable with a prorata contribution toward the injured person's attorney fees under the Common Fund Doctrine. The Contractor may compromise liens as may be reasonable and appropriately consistent with normal business practices.

M. Health Insurance Portability and Accountability Act of 1996 Conformity

The State and the Contractor understand that the coverage provided pursuant to this Agreement constitute creditable coverage pursuant to the federal Health Insurance Portability and Accountability Act of 1996. The State shall issue the Certificates of Coverage for disenrolled subscribers.

N. Interpretation of Coverage

The Contractor, in its Evidence of Coverage booklet (Attachment VII), shall provide clear and complete notice of terms of coverage to subscribers. In the event of ambiguity regarding terms of coverage, the Contractor shall interpret those terms in the interest of the subscriber. In

the event of ambiguity regarding an exclusion from coverage, the Contractor shall interpret the language of the exclusion in the interest of the subscriber. Nothing in this provision shall supersede the common law rules for interpretation of insurance contracts.

V. CLINICAL QUALITY MEASURES AND MANAGEMENT PRACTICES

A. Measuring Clinical Quality

1. The Contractor agrees to provide the State annually with audited clinical quality measures as outlined in Attachment III, Performance Measures. The measures to be provided include selected measures from the most recent version of the ~~Health Plan Employer~~ **Healthcare Effectiveness** Data and Information Set (HEDIS®) released by the National Committee for Quality Assurance (NCQA), ~~and the number of newly enrolled subscribers who received an initial assessment within the first 120 days of enrollment or an assessment within the 12 months immediately preceding the effective date of coverage.~~
2. Data on the measures described in Item V.A.1. above shall include data on subscribers enrolled in the Contractor's plan through the Program and shall cover the experience of the previous calendar year. The report shall be ~~due~~ **submitted** by June 15 of each year ~~and shall be submitted~~ in a format determined by the State. The State hereby notifies the Contractor that compliance with Item V.A.1. and the information received by the State will significantly influence the State's willingness to extend or renew this or subsequent Agreements for provision of service to Program subscribers.
3. All data reported to the State pursuant to Item 1 above shall be audited by a certified NCQA HEDIS® auditor.
4. The Contractor understands that the State may include the results of any of the data included in the reports submitted pursuant to this Item in its annual open enrollment or Program application materials.
5. The Contractor understands that the State intends to collect claims and encounter data from the Contractor during the 2006-07 contract year.
6. The Contractor understands that the State will evaluate the plan's clinical quality measures annually and will take appropriate action if the State determines that the Contractor's continued participation in

the Healthy Families program is not in the best interest of its subscribers.

B. Measuring Consumer Satisfaction

1. The Contractor understands that the State intends to conduct an annual consumer satisfaction survey of Program participants using the most recent release of NCQA's version of the Consumer Assessment of Health Plans Healthcare Providers and Systems Survey (CAHPS®) survey. The Contractor further understands that the State intends to conduct an annual adolescent survey using the Young Adult Health Care Survey (YAHCS), as released by the Child and Adolescent Health Measures Initiative.
2. The Contractor understands that the State will conduct annual CAHPS® and YAHCS surveys, if funding is made available to the State for this purpose, using the services of a vendor selected by the State, hereafter referred to as the CAHPS® Vendor, to collect and analyze CAHPS® and YAHCS data.
3. The Contractor understands that the State intends to release the CAHPS® and YAHCS data to applicants, subscribers and other interested parties. The Contractor understands that the final decision regarding the release of information collected from the CAHPS® and YAHCS surveys shall be made by the State.
4. The State agrees to convene an open Work Group comprised of health plans, State staff, representatives of the State's Quality Improvement Work Group, and the staff of the CAHPS® Vendor to review the survey process and discuss the format and content of any data to be publicly released. The Work Group shall meet periodically during the term of this Agreement in locations throughout the State.
5. If funding is made available, the State shall pay the CAHPS® Vendor on behalf of the Contractor a survey benefit amount, to be determined by the State based upon plan enrollment and survey milestones, which determine the number of families to be surveyed.
6. The Contractor agrees to provide the State with a camera-ready and electronic copy of the Contractor's logo, a signature of a high level Contractor official and sample pieces of the Contractor's stationary and envelopes. The State assures the Contractor that the items listed in this section shall only be used in the conduct of the CAHPS® and YAHCS Surveys.

7. The Contractor understands that the State will evaluate the plan's customer satisfaction survey results annually and will take appropriate action if the State determines that the Contractor's continued participation in the Healthy Families program is not in the best interest of its subscribers.

C. Standards Designed to Improve the Quality of Care

1. The Contractor assures the State that its providers shall use, and the Contractor shall monitor the most recent recommendations of the American Academy of Pediatrics (AAP) with regard to Recommendations for Preventative Pediatric Health Care and the most recent version of the Recommended Childhood Immunization Schedule/United States, adopted by the Advisory Committee on Immunization Practices (ACIP).
2. The Contractor agrees to notify the applicants associated with all subscriber children enrolled in Contractor's plan through the Program, on an annual basis, of the recommended schedule of preventive care visits. The first notice shall be included in the materials provided by the Contractor to new members pursuant to Item II.F.1. Such notification shall be provided via a mailed notice or brochure and shall be provided in English and Spanish. The Contractor agrees that, as soon as more than five percent (5%) of subscribers enrolled with the Contractor or 3,000 subscribers enrolled with the Contractor in the Program are identified as primarily speaking a language other than English or Spanish, the Contractor shall provide the notice in the language primarily spoken by the subscriber.
3. The Contractor shall increase the awareness among its providers of the importance of screening for overweight and obese children using such measures as Body Mass Index. The Contractor shall also increase the awareness among applicants and subscribers of the health risks associated with being overweight and obese, as well as the importance of good nutrition and physical activity. The Contractor shall report to the State by December 10 of each year on current and planned activities to comply with these requirements.

D. Quality Management Processes

1. The Contractor assures the State that the Contractor shall maintain a system of accountability for quality improvement activities which includes the participation of the governing body of the Contractor's organization, the designation of a Quality Improvement Committee,

supervision of the activities of the Medical Director, and the inclusion of contracted physicians and other providers in the process of Quality Improvement development and performance. Evidence of such activities shall be provided to the State upon request.

2. The Contractor represents that its Quality Management processes have been reviewed and found to be satisfactory by one of the following review organizations: The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the National Committee for Quality Assurance (NCQA), or the California Department of Managed Health Care.
3. The State intends to track the Contractor's performance on the measures that are listed in Item V.A.1 and V.B.1. The State's analysis of the Contractor's performance shall include, but not be limited to, the Contractor's performance for the most recent reporting period, a comparison of the Contractor's performance over ~~two reporting periods~~ time, and a comparison of the Contractor's performance with national benchmarks. The Contractor agrees to submit a corrective action plan for performance upon request by the State.
4. The Contractor understands that the State may implement a pay-for-performance system for plans participating in the Program beginning in the 2006-07 contract year. Details of the pay-for-performance system will be developed with input from participating plans. ~~During the 2005-06 contract year, t~~ The State shall give Contractor an opportunity to participate in a work group to determine the specific terms and conditions for payment, as well as the feasibility of such a program. Specific terms and conditions shall be implemented via an amendment to this Agreement.

E. Ongoing Efforts To Improve Quality Measures And Accountability

1. The State intends to convene a Healthy Families Quality Reporting Work Group. The Contractor agrees to participate in the Work Group. The purpose of the Work Group is to discuss technical issues regarding the provision of quality related reports as outlined in Item V.A of this Exhibit. The Work Group will also provide input on other quality activities undertaken by the State to measure the quality of care provided to Program subscribers and the utilization of services through the collection of claims and encounter data.
2. The Work Group shall meet periodically beginning in the fall of 2005 and shall be tasked with developing recommendations for

implementing the Program's clinical quality improvement strategy. The Program's clinical quality improvement strategy may include activities to evaluate and address health disparities among language and ethnic groups and implementation of non-monetary rewards to plans for performance, including the use of performance thresholds.

EXHIBIT B

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EXHIBIT B
BUDGET DETAIL AND PAYMENT PROVISIONS

I. PAYMENT PROVISIONS

The Contractor agrees to arrange for the provision of medical benefits and case management services for subscribers in the Program as described in Exhibit A, Section IV. of this Agreement.

A Fees Provided to Contractor

1. As specified in Item I.B. of this Exhibit, the State shall pay the Contractor a flat fee per month per subscriber child of the age of one and over for all services received by the subscriber and a flat fee per month per subscriber child who is enrolled in the program under the age of one for all services received by the subscriber (infant rate). For a subscriber child who is enrolled in the program under the age of one, the State will pay the infant rate through the end of the month of the child's first birthday, but for no more than twelve (12) months. A subscriber's age will be determined on the first day of each month except as further provided herein. For a child who is enrolled in the program on or after the child's first birthday, the State shall pay at the rate for children age one and over, in accordance with Item I.B.1. of this Exhibit. These fees are set forth in Attachment VI, Confidential Rates of Payment, which is hereby incorporated.
2. In cases of subscriber eligibility and enrollment appeals, which results in liability of health care costs by the State, the Contractor shall pay the provider for services delivered within 30 days following notification by the State of the appeal findings and shall claim reimbursement from the State within 45 days after notification by the State of the appeal findings. The State shall pay the Contractor the actual costs paid by the Contractor for services received. The Contractor shall reimburse and claim for such services at any discounted rate that the Contractor may have in place for the provider in the program and that is accepted by the provider as payment in full. Such payments may only be made by the Contractor and paid by the State when the Contractor receives prior written direction from the State.
3. (ONLY FOR HEALTH PLANS THAT ARE ALSO AIM CONTRACTORS)

Notwithstanding Item I.A.1., the State shall pay the Contractor a lump sum payment to cover an infant born to a woman enrolled in

the AIM Program with the Contractor. The payment shall cover the period from birth through the end of the month following the month of birth. The State shall make the lump sum payment in the month following the reporting of the birth by the Contractor to the Administrative Vendor for the HFP/AIM programs, for only those infants who have been reported to the Administrative Vendor in accordance with the provisions in Exhibit A, Item II.B. After the second month, if the infant remains enrolled with the Contractor, the State shall pay the Contractor at the infant rate specified in Item I.A.1 through the end of the month of the Child's first birthday, but for no more than ten (10) months. The lump sum fee is set forth in Attachment VI, Confidential Rates of Payment. Infants who were not reported by the Contractor in accordance with Exhibit A, Item II.B shall be paid at the infant rate specified in Item I.A.1 upon enrollment, pursuant to Item I.B.

B. Payment Schedule

1. For the first month or partial month of a subscriber's coverage the State agrees to pay one hundred percent (100%) of the fee described in Item I.A.1. of this Exhibit for subscribers with effective dates of coverage on the first (1st) through fifteenth (15th) day of the month. No fee shall be paid for the first partial month of coverage for subscribers whose coverage begins on the sixteenth (16th) through thirty-first (31st) day of the month. The State agrees to pay the fee within fifteen (15) days after the completion of the month of coverage.
2. For all months of coverage after the first month in which a subscriber's coverage becomes effective, the State agrees to pay the fee described in Item I.A.1. of this Exhibit. The State agrees to pay the fee within fifteen (15) days after the completion of the month of coverage.

C. Special Enrollment Materials Cost

In any event of an assignment of this Agreement or other transaction through which any entity purchases or otherwise acquires the Contractor's program enrollment, an early termination, or the removal of coverage in a service area by the Contractor which requires a special open enrollment, the Contractor agrees to pay the State for actual costs or \$9.00 per affected subscriber, whichever is greater, for subscribers enrolled in the Contractor's plan who must be moved to another participating plan.

The Contractor understands that the State does not intend to permit any special open enrollment between March 1 and June 30 of any year.

Nothing in this Item I.C. shall be construed to limit the State's sole discretion to disapprove any proposed assignment pursuant to Item III of Exhibit C.

II. FISCAL CONTROL PROVISIONS

A. Minimum Loss Ratio

1. The Contractor agrees that administrative costs shall be reasonable. The Contractor agrees that, once the Contractor's plan has a minimum of 1,000 enrolled subscribers per month for six or more months of a benefit year, the minimum loss ratio for services provided to all subscribers pursuant to this Agreement shall be ____%. For reporting purposes, the Contractor's loss ratio shall be calculated in aggregate for all subscribers, using the following formula:

a/b

Where "a" is :Total covered benefit and service costs of Contractor including incurred but not reported claim completion costs minus subscriber co-payment requirements and minus amounts recovered pursuant to Exhibit A, Items IV.I, IV.J. and IV.K. of this Agreement, and

where "b" is: Total premiums received by the Contractor.

2. The Contractor shall report the previous benefit year's loss ratio, **and an interim loss ratio for July through November of the current year,** by January 1 of each year.
3. The Contractor understands that the State may make the results of the loss ratio report listed in Item 2. above available to the public.
4. As part of evaluating the quality of the Contractor's operations, the State has established a goal to ensure one evaluation of the Contractor's reported loss ratio is completed on behalf of the Contractor during the three year term of this Agreement. The evaluation will be done in accordance with standards and procedures for audits, reviews, examinations and evaluations set forth in Exhibit D., Item II.D. of this Agreement. The State will notify the Contractor if the Contractor will be scheduled for an evaluation during the contract. The State will work with the Contractor regarding scheduling evaluation dates. The State will contract on behalf of the Contractor for the performance of the evaluation. The evaluations will be performed by the California Department of

Managed Health Care or a qualified entity to be selected by the State. The State will pay the Department of Managed Health Care or selected qualified entity on behalf of the Contractor for the cost of the loss ratio evaluation.

5. The Contractor agrees that if the evaluation described in Item II.A.4 determines that (i) the minimum loss ratio is less than the ratio specified in Item II.A.1, and (ii) the Contractor made a net profit in connection with the services provided, the Contractor shall credit the State with the amount of net profit. The amount of net profit shall be the amount determined as such by the results of the evaluation described in Item II.A.4.

6. The Contractor shall credit the State with the amount of net profit described in Item II.A.5.a as follows:

a. Commencing with the first month after the completion of the evaluation described in Item II.A.4 and written notification to the Contractor, the credit of the amount of net profit described in Item II.A.5 shall be applied to the amounts due pursuant to Item I.B until the amount of the credit is entirely exhausted.

b. If this Agreement is terminated prior the application of credits described in Item II.A.5, then within thirty (30) days of the receipt by the Contractor of written notification of the amounts of the net profit determined by the evaluation described in Item II.A.4, the Contractor shall pay the State such amounts.

B. Payment Limitation

1. Only subscribers for whom a premium is paid by the State to the Contractor are entitled to health services and benefits provided hereunder and only for services rendered or supplies received during the period for which the subscriber is enrolled.
2. The Contractor agrees to reconcile, on at least a monthly basis, eligibility data provided by the State with the Contractor's data on persons for whom claims, capitation payments, and other payments related to services and benefits were made in the Program. The Contractor shall make any necessary adjustments indicated by the reconciliation to ensure compliance with Item II.B.1. The Contractor shall maintain records of these reconciliations in accordance with Exhibit D, Item II.C. of this Agreement. The Contractor shall ensure that only the costs of services and benefits

covered in the Program are included in the numerator of the loss ratio calculation set forth in Item II.A.

3. The State shall not be liable for any reconciliation discrepancies reported by the Contractor more than sixty (60) days from the date the monthly audit file is provided to the Contractor, pursuant to Exhibit A, Item II.J.8.

C. Availability of Federal Funds

1. It is mutually understood between the parties that this Agreement may have been written for the mutual benefit of both parties based on then-existing regulations and federal executive agencies' interpretation and application of relevant statutes but, before ascertaining the availability of Congressional appropriation of funds, in order to avoid program and fiscal delays which would occur if the Agreement were executed after that determination was made.
2. This Agreement is valid and enforceable only if sufficient funds are made available to the State by the United States Government for the purposes of this program for the fiscal years covered by the term of this Agreement. In addition, this Agreement is subject to any additional restrictions, limitations, or conditions made applicable at any time by:
 - a. ~~enacted by the~~ enactments of Congress or ~~to any statute enacted by the Congress~~
 - b. regulations promulgated or amended by federal executive agencies, or
 - c. the interpretation or application by federal executive agencies of relevant regulations and statutesthat may affect the provisions, terms or funding of this Agreement in any manner.
3. The parties mutually agree that, if Congress does not appropriate sufficient funds for the Program or, as described in Exhibit B, Items II.C.2.a.b. and c., restrictions, limitations or conditions affect the provisions, terms or funding of this Agreement, this Agreement shall be amended to reflect any reduction in funds and any restrictions, limitations or conditions that affect the Agreement's provisions, terms or funding.

4. The State has the option to invalidate this Agreement under the 30 day termination clause in Exhibit D, Item I.B. or to amend the Agreement to reflect any reduction in funds.

D. Prior to Fiscal Year/Crossing Fiscal Years

It is mutually agreed between the parties that this Agreement may have been signed and executed prior to the start of the 2005-06 State Fiscal Year, before ascertaining the availability of funds for the 2005-06 State Fiscal Year. This Agreement has also been written with a term that crosses State Fiscal Years, and therefore before ascertaining the availability of legislative appropriation of funds for the 2006-07 and 2007-08 State Fiscal Years. This Agreement is valid and enforceable only if sufficient funds are made available through the 2006-07 and 2007-08 State Budgets for the purposes of this Program. In addition, this Agreement is subject to any additional restrictions, limitations, or conditions enacted in statute by the State Legislature which may affect the provision, term or funding of this Agreement in any manner. It is mutually agreed that if the State Legislature does not appropriate sufficient funds for this Program, the Agreement shall be amended to reflect any reduction in funds and enrollment shall be curtailed by the State proportionately.

E. Healthy Families Fund Encumbrance

There is no specific maximum amount assigned to this Agreement. Rather, the Contractor is paid through a general encumbrance from the Healthy Families Fund apportioned to the Contractor on an as needed basis. Payments under this Agreement are limited to the provisions of Items I.A. and I.B. of this Exhibit.

F. Fiscal Solvency (DMHC)

The Contractor agrees that it shall at all times maintain the reserves required under the Knox-Keene Health Care Service Plan Act of 1975, as amended, and the regulations promulgated there under by the Department of Managed Health Care, including the Tangible Net Equity regulations.

Evidence of above solvency shall be made available to the State upon request. If the Contractor's reserves fall below the statutory requirement, the Contractor shall within 15 calendar days notify the State in writing and by telephone communication with the Board's Executive Director and its Chief Deputy Director.

OR

F. Fiscal Solvency (DOI)

The Contractor agrees that it shall at all times comply with all solvency requirements of its licensing statute and regulations and shall at all times maintain one of the following:

- a. A rating of A+ under Best insurance rating, or
- b. A surplus capable of paying one month of Contractor's paid claims. The amount of one month of the Contractor's paid claims shall be established by averaging claims paid in each of the previous twelve (12) months.

Evidence of above solvency shall be made available to the State upon request. If the Contractor's reserves fall below the statutory requirement, the Contractor shall within 15 calendar days notify the State in writing and by telephone communication with the Board's Executive Director and its Chief Deputy Director.

G. Federally Funded Programs (Medicare & Medicaid)

The Contractor shall remain in good standing with the State Department of Health Services for services provided to Medi-Cal subscribers, with the federal Centers for Medicare and Medicaid Services for services provided to Medi-Cal or Medicare subscribers, and with the Office of the Inspector General of the Department of Health and Human Services. On request, the Contractor agrees to provide the State immediately with copies of all correspondence received from the Department of Health Services, the Centers for Medicare and Medicaid Services, and the Office of the Inspector General of the Department of Health and Human Services which pertains to the Contractor's standing with the respective departments. In addition, the Contractor shall immediately notify the State of any investigations in which there are allegations related to fraud, including but not limited to: 1) the receipt of an administrative subpoena from any state or federal agency, unless the Contractor is advised that it is not the target or subject of the investigation; 2) the receipt of a grand jury subpoena from any state or federal court, unless the contractor is advised that it is not the target or subject of the investigation; 3) the execution of a search and seizure warrant at any of the contractor's offices or locations related to such investigations; and 4) the filing of any charges against the contractor in any state or federal court related to such investigations. The Contractor shall immediately notify the State if the Contractor receives a letter of pending sanction or formal corrective action (such as corrective action addressing audit findings or systemic problems) from the State Department of Health Services, the Centers for Medicare and Medicaid

Services, or the Office of the Inspector General of the Department of Health and Human Services.

H. Licensing Sanction Notifications (DMHC)

The Contractor agrees that it shall remain in good standing with the Department of Managed Health Care. On request, the Contractor agrees to provide the State with copies of all correspondence from the Department of Managed Health Care that pertains to the Contractor's standing with its regulatory entity. The Contractor shall immediately notify the State if the Contractor receives a letter of pending sanction or formal corrective action (such as corrective action addressing audit findings or systemic problems) from the Department of Managed Health Care.

OR

H. Licensing Sanction Notifications (DOI)

The Contractor agrees that it shall remain in good standing with the Department of Insurance. The Contractor agrees to provide the State with copies of all correspondence from the Department of Insurance that pertains to the Contractor's standing with their regulatory entity. The Contractor shall immediately notify the State if the Contractor receives a letter of pending significant sanction or corrective action from the Department of Insurance.

I. Contractor Performance Standards, Liquidated Damages and Remedy for Non-Performance

1. The State shall monitor the Contractor's compliance with the terms of this Agreement. The State shall attempt to work with the Contractor to assist the Contractor in fulfilling its obligations under this Agreement.
2. If the State finds the Contractor to be out of compliance with the terms of the Agreement, the State may, after thirty (30) days written notice to the Contractor and an opportunity to cure such non-compliance or default within that thirty (30) day period, suspend thereafter enrollment of eligible subscribers in the Contractor's health plan. Notice provided to the Contractor pursuant to this section shall include a description of those actions/standards the Contractor must achieve for enrollment to be resumed. Resumption of enrollment is at the discretion of the State.

3. The State and the Contractor agree that the following sections of this Agreement contain objective performance standards to be met by the Contractor which shall be monitored by the State:
 - a. Exhibit A, Item II.F. Identification Cards, Provider Directory, and Evidence of Coverage or Certificate of Insurance Booklet
 - b. Exhibit A, Item II. K. Network Information Service
 - c. Exhibit A, Item II. L.2. and 3. Traditional and Safety Net Providers Reports
 - d. Exhibit A, Item III. A. Telephone Service for Subscribers
 - e. Exhibit A, Item III.B.2. Grievance Report
 - f. Exhibit A, Item III.C.4.c. Cultural and Linguistic Services Report
 - g. Exhibit A, Item IV.B.3. California Children's Services Report
 - h. Exhibit A, Item IV.D.3. Mental Health: Services for Subscribers with Serious Emotional Disturbance Report
 - i. Exhibit A, Item IV.H.3. Copayments Report
 - j. Exhibit A, Item V.A. Measuring Clinical Quality
 - k. Exhibit A, Item V.B. Measuring Consumer Satisfaction
 - l. Exhibit A, Item V.C. Standards Designed to Improve the Quality of Care
 - m. Exhibit B, Item I.C. Special Enrollment Materials Cost
 - n. Exhibit B, Item II.A.2. Minimum Loss Ratio Report
 - o. Exhibit B, Item II.B.2. Payment Limitation Reconciliation
4. If, in the State's view, the Contractor has not fulfilled its contractual responsibilities with regard to one or more of the items identified in Item 3. above, the State shall notify the Contractor in writing of the Contractor's lack of performance. If the Contractor does not improve performance to an acceptable level within 5 business days after receipt of such notice, the State may impose liquidated

damages on the Contractor of no more than five percent (5%) per day of the Contractor's average daily fee per day beginning on the sixth business day following notification. If the Contractor's performance does not improve within 15 additional business days from the first day liquidated damages were imposed, the State after written notice to the Contractor, may increase the liquidated damages to ten percent (10%) per day of the Contractor's average daily fee per day beginning on the 16th business day following the receipt of notification of non-performance until the Contractor is in compliance with the Contract. The Contractor's average daily fee is calculated by taking the Contractor's total monthly premium and dividing by the number of calendar days in that particular month. In no event shall the total amount of liquidated damages imposed for the items identified in Item 3. above exceed ten percent (10%) per day.

5. All liquidated damages must be paid to the State within ten (10) calendar days of receipt of an assessment letter.
6. If the State determines that the Contractor's non-performance was caused in whole or in part by the State, the State shall reduce the damages proportionately.
7. The parties agree that the damages for failure to provide the deliverables and/or meet the contractual performance standards described herein are not susceptible to exact calculation in advance and that the liquidated damage amounts specified in this Agreement represent an agreed estimate of what the future damages would be. These liquidated damages are not intended to be penalties.

J. Licensure (DMHC)

Department of Managed Health Care Licensees

The Contractor assures the State that it has a license to provide services under this Agreement from its regulatory agency, the Department of Managed Health Care.

OR

J. Licensure (DOI)

Department of Insurance Licensees:

The Contractor assures the State that it has a license to provide services under this Agreement from its regulatory agency, the Department of Insurance.

K. Risk Assessment and Adjustment Process

The State may convene a Risk Assessment/Risk Adjustment Work Group for the purpose of exploring the necessity and feasibility of assessing and correcting for risk mix differences between health plans. The Contractor agrees to provide technical staff to participate in the Work Group to be convened by the State.

Attachment I
Instructions for Completing the Healthy Families Program
Plan Coverage Area Workbook

A customized Plan Coverage Area Workbook for the 2008-09 benefit year will be emailed to each plan separately by **October 31, 2007**. The workbook contains several worksheets that outline your existing coverage area(s), and also contains instructions on how to identify changes to your plan's existing coverage area(s) for the upcoming 2008-09 benefit year. You must e-mail a copy of the completed workbook by **December 7, 2007** to: HFPContract08@mrmib.ca.gov.

Note: MRMIB must receive confirmation that you have obtained regulatory approval for any expansion areas. If you are governed by the DMHC, you must allow 45 to 90 days for DMHC's approval. Confirmation of your regulatory approval from DMHC should be sent via email to HFPContract08@mrmib.ca.gov no later than March 14, 2008. MRMIB reserves the right, at its sole discretion, to exclude the expanded coverage areas from your 2008-09 contract amendment if your regulatory approval for expansion areas is not received by MRMIB by March 14, 2008.

ATTACHMENT II PROVIDER DATA FILE REQUIREMENTS

Provider Data File Requirements

Data Elements

The provider data file should contain one record for each unique provider location. In other words, a provider that practices in three different offices should be listed three times. Individual and facility records should be contained in separate files. If codes are used for any fields (e.g., specialties, hospital affiliations, etc.), an appropriate decode table should be included. The following items should be included, with one field per item:

For Both Individual Providers and Facilities

1. Address
2. Suite
3. City
4. State
5. ZIP
6. County
7. Phone number (with area code)
8. Plan Identifier
9. Tax ID
10. PCP / Clinic ID National Provider ID (NPI)

For Facility Providers

1. Name
2. Facility Type (Hospital)

For Individual Providers

1. Social Security Number
2. DEA Number
3. Last Name
4. First Name
5. Middle Name or Initial
6. Suffix
7. Degree
8. Gender
9. Role (PCP, Referral, Self-Referral)
10. Specialty(ies)
11. State License Number
12. Date of Birth
13. Board Status
14. Open/Closed Practice Indicator
15. Languages Spoken
16. Hospital Affiliation(s)
17. Clinic/Group/IPA Affiliation(s)

Acceptable File Format

Delimited ASCII file with a field description is the only acceptable file format.

Acceptable Media Format

Internet transfer is the only acceptable media format. Feel free to use some form of common data compression (such as PKZIP). If data compression is used, please note the method of compression.

Sample File Format

The file structures shown below represents a recommended file format for submitting physician (and other healthcare provider) data, and facility data. **Note that the file format must comply with the requirements listed on page 1.**

Provider File

Field Name	Width	Occurrences	Description / Definition
Plan Identifier	15	1	Name of the plan or panel
First	25	1	First name field
Middle	25	1	Middle name/initial field
Last	70	1	Last name field
Suffix	25	1	Jr, Sr, III, IV, etc.
Gender	1	1	Male, Female, or Unknown
Degree	25	1	MD, DO, etc.
Address	60	1	Street address or physician office location
Suite	30	1	Secondary address
City	45	1	
State	2	1	
Zip	5	1	
County	45	1	
Phone	10	1	Area code and number without dashes or spaces
Open Practice	1	1	Accepting patients, closed, unknown
PCP / Clinic ID <u>National Provider ID (NPI)</u>	15	1	This is the National Provider ID to be used for enrollment purposes an identifier meaningful to the health plan, established under HIPAA 1996.
DEA Number	15	1	Drug enforcement agency number
License number	9	1	
DOB	8	1	Physician's Date of Birth (MMDDYYYY)
SSN	9	1	Physician's Social Security Number
Tax ID	9	1	Federal Tax ID
Role	1	1	Role within the plan or panel; Primary care, Referral, or Self-referral
Specialty	60	8	Field indicating practice specialty; if a code is used, a translation table must be included
Spoken Languages		8	Field indicating language spoken at the provider's location or by provider; if a code is used, a translation table must be included.
Language Location/Provider	60 1		Language Language spoken at location (L), by Provider (P), or both (B)
Board Status	1	8	Certified, Eligible, Not Certified, or Unknown
Hospital	60	16	Field indicating Physician's hospital affiliation
Clinic Group	50	8	Name of medical group, IPA or clinic
Contracted Medi-Cal Managed Care Provider	1	1	Y/N-Yes or No indicator if the providers is a contracted provider for Medi-Cal Managed Care

Facility File

Field Name	Width	Occurrences	Description / Definition
Plan Identifier	15	1	Name of the plan or panel
Hospital Name	70	1	Name of facility
Address	60	1	Address of facility
Suite	30	1	Secondary address
City	45	1	
State	2	1	
Zip	5	1	
County	45	1	
Phone	10	1	Area code and number without dashes or spaces
Tax ID	9	1	Federal Tax ID
Facility Type	8	1	Hospital, Clinics, SNF etc.

ATTACHMENT III
SCHEDULE OF PERFORMANCE MEASURES
Childhood Indicators - Ages 12 Months Through 18 Years

Note This schedule outlines the performance measures to be reported by health plans during the term of this contract. The description of HEDIS® measures contained in this schedule of performance measures is not meant to be a comprehensive description of required HEDIS® measures. Plans are expected to have the most current HEDIS® information and to follow the specifications for the following measures in that document.

FOR THE 2007-08 CONTRACT PERIOD

1) CHILDHOOD IMMUNIZATION STATUS (HEDIS® Measure)

The percentage of HFP enrolled children who turned two years old during the reporting year, who were continuously enrolled for 12 months immediately preceding their second birthday (including members who have had not more than one break in enrollment of up to 45 days during the 12 months immediately preceding their second birthday), and who have received the following immunizations:

- Four DTP or DTaP vaccinations by the second birthday with at least one diphtheria and one tetanus falling on or between the child's first and second birthdays.
- Three polio (IPV or OPV) vaccinations by the second birthday
- One MMR between the first and second birthdays
- Three H influenza type B vaccinations with different dates of service by the child's second birthday and with at least one of them falling on or between the first and second birthdays
- Three hepatitis B vaccinations by the second birthday (with one of them falling between the six month and the second birthday)
- At least one chicken pox vaccination (VZV), with a date of service falling on or between the child's first and second birthdays
- A combined rate including children who have received all of the immunizations above.

2) CHILDREN'S ACCESS TO PRIMARY CARE PROVIDERS (HEDIS® Measure)

The percentage of children who have had at least one visit to a pediatrician, family physician, and other health care provider during the reporting year. Four separate cohorts are reported:

- Percentage of children age 12 through 24 months who were continuously enrolled during the reporting year who have had one (or more) visits with a health plan primary care provider during the reported year.
- Percentage of children age 25 months through 6 years who were continuously enrolled during the reporting year who have had one (or more) visits with a health plan primary care provider during the reported year.
- Percentage of children age 7 through 11 years who were continuously enrolled during the reporting year and the year prior who have had one (or more) visits with a health plan primary care provider during the reporting year or the year preceding the reporting year.
- Percentage of adolescents 12-18 years of age who were continuously enrolled during the reporting year and the year prior who have had one (or more) visits with a health plan primary care provider during the reporting year or the year preceding the reporting year.

3) *WELL CHILD VISIT IN THE THIRD, FOURTH, FIFTH, AND SIXTH YEARS* (HEDIS® Measure)

The percentage of HFP enrolled members who were age 3 through 6 years during the reporting year who were continuously enrolled during the reporting year and who received one or more well-child visit(s) with a primary care provider during the reporting year. Members who have had no more than one break in enrollment of up to 45 days per year should be included in this measure.

4) *ADOLESCENT WELL-CARE VISITS* (HEDIS® Measure)

The percentage of HFP enrolled members who were 12 through 18 years during the reporting year who were continuously enrolled during the reporting year and who had at least one comprehensive well-care visit with a primary care provider during the reporting year. Members who have had not more than one break in enrollment of up to 45 days per year should be included in this measure.

5) *ALCOHOL AND OTHER DRUG SERVICES UTILIZATION* (HEDIS® Measure)

Percentage of Members Receiving Inpatient, Intermediate, and Ambulatory Services.

The number and percentage of HFP members receiving alcohol and other drug services during the reporting year in the following categories: any alcohol and other drug services; inpatient alcohol and other drug services; intermediate alcohol and other drug services; and ambulatory alcohol and other drug services.

6) *USE OF APPROPRIATE MEDICATIONS FOR ASTHMA* (HEDIS® Measure)

The percentage of enrolled members 5 through 18 years of age during the measurement year, who were identified as having persistent asthma during the year prior to the measurement year and who were appropriately prescribed medication during the measurement year.

7) MENTAL HEALTH UTILIZATION (HEDIS® Measure)

The number and percentage of members, by age and sex, receiving mental health services during the measurement year in four categories of service:

- any mental health services (inpatient, day/night, ambulatory)
- inpatient mental health services
- day/night mental health services
- ambulatory mental health services

8) WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE (W15) (HEDIS® Measure)

The percentage of enrolled members who turned 15 months old during the measurement year, who received either zero, one, two, three, four, five, six or more well-child visits with a primary care practitioner during their first 15 months of life. A child should be included in only one numerator (e.g., a child receiving six well-child visits would not be included in the rate for five or fewer visits.)

9) CHLAMYDIA SCREENING IN WOMEN (HEDIS® Measure)

The percentage of women 16-18 years of age who were identified as sexually active, who were continuously enrolled during the measurement year with no more than one gap in enrollment of up to 45 days during that time and who had at least one test for Chlamydia during the measurement year.

10) APPROPRIATE TREATMENT FOR CHILDREN WITH UPPER RESPIRATORY INFECTION (URI) (HEDIS® Measure)

The percentage of enrolled members 3 months through 18 years of age during the measurement year, who were given a diagnosis of upper respiratory infection and were not dispensed an antibiotic prescription on or three days after the Episode date.

11) APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS (CWP) (HEDIS® Measure)

The percentage of enrolled children 2 through 18 years of age during the measurement year, who were given a diagnosis of pharyngitis, prescribed an antibiotic and received a group A streptococcus (strep) test for the episode.

Attachment VII
Healthy Families Program Health Plan Fact Sheet
2008-2009 Contract Period

The purpose of the Health Plan Fact Sheet is to obtain information from our plan partners in the areas of provider network capacity, compensation structure, and delivery of health care services.

Please read the instructions provided for each question and respond accordingly. Responses should be typed in the gray form fields provided. To move to the next form field, press the TAB key. To go back to a previous form field, hold the SHIFT key + press the TAB key.

Verify all chart figures and responses for accuracy. The appropriate plan representative is to provide their signature on the last page prior to submitting to MRMIB.

The sections are labeled as follows:

- I. Network Capacity and Physician/Hospital Compensation
- II. Delivery of Health Care Services
- III. Miscellaneous Questions
- IV. Plan Signature

NOTE: The Fact Sheet must be e-mailed by December 12, 2007 to:

HFPContract08@mrmib.ca.gov

If you have any questions regarding this form, contact Willie Sanchez, Benefits Specialist at (916) 323-2072.

Plan Name

Plan Contact

Phone Number

I. Network Capacity and Physician/Hospital Compensation

1. Complete the Pediatric and Adolescent Primary Care Practitioners (PCP) chart below.

Pediatric / Adolescent Primary Care Practitioners	2005	2006	2007
Total number of PCPs in the provider network as of January 1 st for the calendar year.	#	#	#
Number of PCPs added to the provider network during the calendar year. (Indicate number and percentage.)	#	#	#
	%	%	%
Number of PCPs that left the provider network during the calendar year. (Indicate number and percentage.)	#	#	#
	%	%	%
Total number of PCPs in the provider network as of December 1 st .	#	#	#

2. Complete the pediatric and adolescent specialists chart below.

Pediatric / Adolescent Primary Care Specialists	2005	2006	2007
Total number of specialists in the provider network as of January 1 st for the calendar year.	#	#	#
Number of specialists added to the provider network during the calendar year. (Indicate number and percentage.)	#	#	#
	%	%	%
Number of specialists that left the provider network during the calendar year. (Indicate number and percentage.)	#	#	#
	%	%	%
Total number of specialists in the provider network as of December 1 st .	#	#	#

3. Complete the Health Plan Primary Care Physician (PCP) Network Capacity Chart below. List the percentage of providers accepting new patients and the estimated number of members that the PCPs can serve by county as of January 1, 2008.

Health Plan Primary Care Physician (PCP) Network Capacity Chart					
COUNTY	Number of current HFP members in the plan's service area (for each county served)	Number of HFP Pediatric & Adolescent PCPs	Number of HFP Pediatric & Adolescent PCPs accepting new patients	Percentage of HFP Pediatric & Adolescent PCPs accepting new patients	Estimated number of HFP Pediatric & Adolescent patients that can be served in each county
Alameda					
Alpine					
Amador					
Butte					
Calaveras					
Colusa					
Contra Costa					
Del Norte					
El Dorado					
Fresno					
Glenn					
Humboldt					
Imperial					
Inyo					
Kern					
Kings					
Lake					
Lassen					
Los Angeles					
Madera					
Marin					
Mariposa					
Mendocino					
Merced					
Modoc					
Mono					
Monterey					
Napa					
Nevada					
Orange					
Placer					
Plumas					
Riverside					
Sacramento					
San Benito					
San Bernardino					
San Diego					
San Francisco					
San Joaquin					
San Luis Obispo					
San Mateo					
Santa Barbara					
Santa Clara					
Santa Cruz					
Shasta					
Sierra					
Siskiyou					
Solano					
Sonoma					
Stanislaus					
Sutter					
Tehama					
Trinity					
Tulare					
Tuolumne					
Ventura					
Yolo					
Yuba					

4. Describe how plan providers notify the plan when they no longer accept new HFP patients.

Response:

II. Delivery of Health Care Services

Respond to the following topics and describe the procedures used for delivering health care services.

Member Services - Mental Health and Substance Abuse
1) How the plan assesses the mental health needs of members. Include a description of any mental health screening or assessment tools used by the plan. Where applicable, identify tools used for specific age ranges as well as how the plan assesses the mental health and substance abuse needs of Limited English Proficient (LEP) children. Response:
2) How the plan assesses the needs of members in regards to alcohol use, drug abuse, and tobacco use. Include a description of any screening or assessment tools used by the plan. Where applicable, identify how age appropriate assessments are made as well as how plans assess the mental health and substance abuse needs of Limited English Proficient (LEP) children. Response:
3) Describe the process for providing alcohol, drug abuse and tobacco prevention services. Response:
4) Specify what, if any, arrangements are made for the provision of services once the maximum alcohol and drug benefit limit is reached. Response:
5) Will the plan subcontract with a mental health behavioral company or a county mental health program, or will the plan have mental health providers either on staff or on contract? If a behavioral health company is used, provide the name of the company. If the plan uses a behavioral health company or contract providers, describe the level of supervision and accountability the plan maintains in order to make sure that appropriate services are delivered. Response:
6) Will the plan use the substitution of inpatient mental health days for day treatment, outpatient visits, or residential treatment days to provide more than the 20 outpatient visits as authorized in Article 3. of the Program Regulations? If yes, explain the substitution method that is used. Response:
7) To what extent are mental health providers authorized or encouraged to incorporate family members and primary caregivers in the treatment of children with mental health needs? Response:
8) Describe how members are notified that the plan is referring the member to the county for SED evaluation. If members are notified in writing, attach a sample of the plan's notification letter. Response:
9) What steps does the plan take to assure that the child will continue to receive required mental health services through the plan if the county mental health department makes a determination that an HFP member has an SED condition, but there will be a delay in providing services (due to waiting lists, lack of resources, etc.)? Response:
10) Provide the name and contact information for the plan's designated Mental Health Services Liaison and describe how the liaison coordinates and collaborates with each County Mental Health Department in which Contractor serves Program subscribers. (See Exhibit A, Item D.2.f) Response:

Member Services – Asthma	
1) The plan's guidelines for providers to diagnose, manage and monitor asthma for individuals with persistent or high risk asthma. Indicate if the plan provides incentive and reward structures that encourage quality asthma care.	Response:
2) An explanation of the plan's asthma registry and/or patient monitoring system to track utilization and outcomes.	Response:
3) A list of asthma resources provided to members.	Response:
4) How and when children with asthma are educated to use their inhaler or other medication.	Response:
5) How and when the parents or caregivers are educated in the treatment/care of the child. Are home visits offered?	Response:
6) How and when education is provided to recognize early signs and symptoms of asthma episodes and appropriate responses. Provide a copy of educational materials.	Response:
7) How and when HFP subscribers with persistent asthma are notified of their need to get their annual influenza vaccination? Identify the age group of these subscribers receiving annual influenza immunizations.	Response:
8) The method used by the plan to facilitate coverage and reimbursement for the following asthma services and supplies: <ul style="list-style-type: none"> • primary asthma education • management and prevention supplies such as inhaler spacers and pillow/mattress encasements • duplicate medication for HFP children (e.g. one for home use and one for school/child care use) 	Response:
9) How and when the plan encourages providers to discuss smoking-cessation with: <ul style="list-style-type: none"> • HFP subscribers with persistent asthma • HFP subscribers' parents or guardians 	Response:

Members Services - Obesity
1) How plan providers are made aware of the importance of screening for overweight and obese children and the documents and/or tools the plan uses to make plan providers aware of the importance of screening for obesity. (See Exhibit A, Item V.C.3.) Response:
2) How the plan informs applicants and members about the health risks associated with being overweight or obese and the importance of good nutrition and physical activity. Include descriptions of the documents or programs the plan uses to inform applicants and members about the obesity prevention programs the plan has created or uses to assist members. (See Exhibit A, Item V.C.3.) Response:
3) How the plan and/or providers determine/monitor the success of their weight management programs offered to HFP members. Include the steps the plan takes to improve the quality and types of programs offered. Response:

Member Services – Diabetes
Describe any diabetes prevention, education and treatment programs provided by the plan or plan providers. Response:

Member Services - Teen Screenings
1) Describe any programs or tools used by the plan or plan providers to encourage annual preventive screenings for teens. (Attach samples if available) Response:
2) Describe how the plan ensures providers screen teens for risky behaviors, and how counseling is provided on topics such as smoking, sexual activities and STD's, weight, healthy diet and exercise, depression, emotional health and relationship issues. (Attach samples if available) Response:
3) What incentives, if any, does the plan use to encourage teens to receive preventive services? Describe the success of the incentives. Response:

III. Miscellaneous Questions

1. Describe any agreements contemplated or in progress between the plan and other parties which may effect the plan's ownership, corporate structure or management during the January 2008 through June 2009 time period (as allowed by State and Federal Law).

Response:

2. Describe any restrictions or pending reviews by state (including the Medi-Cal program) or federal authorities for non-compliance with state or federal regulations or contracts for medical services.

Response:

3. Describe the process used by the plan to assure that any changes in contractual arrangements that will impact the plan's provider network are reported in a timely manner to the State.

Response:

IV. Plan Signature

This 2008 Health Plan Fact Sheet for the Healthy Families Program must be signed by the person authorized to sign the health plan's contract.

To the best of my knowledge, all statements and data reported by _____ (health plan) in this Health Plan Fact Sheet 2008/2009 for the Healthy Families Program are true and accurate. I understand that all responses to questions included in the Fact Sheet, except items III.1-3, may be included in comparative charts in the Healthy Families Program brochure or other public documents produced by MRMIB.

Signed

Name

Title

Date

**Instructions for the Healthy Families Program
Plan Descriptions, Frequently Asked Questions (FAQ) Chart and Language Grid**

Your Plan Description, FAQ Chart and Language Grid from the 2007-08 Handbook will be e-mailed to you by Wednesday October 31, 2007. Please identify if any changes are needed to these documents by placing a check mark on the appropriate line below.

Plan Description

☐ We do not have changes for the current plan description.

☐ We have made the enclosed changes to the current plan description.

FAQ Chart

☐ We do not have changes for the current FAQ chart.

☐ We have made the enclosed changes to the current FAQ chart.

Language Grid

☐ We do not have changes for the language grid

☐ We have made the enclosed changes to the language grid

Plan Contact Information	
Name:	<input type="text"/>
E-mail address:	<input type="text"/>
Telephone Number:	<input type="text"/>
Fax Number:	<input type="text"/>
Date of submission:	<input type="text"/>

How to update the documents

Your **Plan Description** will be emailed to you in Microsoft *Word* format. Your **FAQ chart** and **Language Grid** will be emailed in Microsoft *Excel* format. If you don't have any changes, check the appropriate line above. Read below for more instructions.

By **December 7, 2007**, e-mail the cover page of these instructions and any changes to your Plan Description, FAQ Chart and Language Grid to HFPCContract08@mrmib.ca.gov for approval.

Plan Description - Any changes to your current plan description should be consistent with the following:

1. Plan Description Length and Typeface

Plan descriptions must be limited to no more than 310 words. Descriptions that are too long will be revised. The font and font size can be no smaller than Times 10 point. Plans will have the opportunity to review the revised information and layout in the HFP Handbook before the final production. Please note that additional changes will **not** be accepted during this review.

2. Plan logo, toll-free numbers, and language capabilities

The plan logo should appear in the designated 1" x 2 ¾ " space on the page. The toll-free phone number should appear under the logo and all toll-free numbers for each service area or different services should be included. Also, please include the phone hours, days of operation and language capabilities. (See sample below)

LOGO
1-800-111-2222
Call 7am to 7pm
English and Spanish

3. Text to be included

- **Why choose your plan:** provide highlights about your plan including, but not limited to: customer service, number of HFP providers-pharmacies-hospitals in your network, health and wellness programs, etc.
- **How the plan works:** provide a clear and concise description for this section. This should be the longest section.
- **How to choose:** provide brief instructions on how to select your plan.

FAQ Chart and Language Grid - The FAQ chart and Language Grid appear on two separate tabs in one Excel file. The FAQ chart will prompt you to choose your responses from a drop-down list of answers next to each question. The Language Grid includes your threshold languages for printed materials from the 2007-08 benefit year. Update the Grid with any changes by using the *Track Changes* feature in Excel. Refer to Exhibit A, Scope of Work, Section III. C.(2)(a) for information on how to calculate threshold languages.

**Healthy Families Program
Health Plan
Evidence of Coverage (EOC) or Certificate of Insurance (COI) Instructions**

Indicate any changes to your current (2007-08) EOC/COI by submitting **only** the pages with changes indicated on them, **not** your entire EOC/COI. When submitting the changes, include the entire page that will be changed so we can review the change in context. Use ~~striketrough~~ for text you are deleting and underline text you are adding. Additionally, provide a separate document summarizing the changes your plan is proposing, including the page number and an explanation for each change.

You are highly encouraged to use MRMIB's model HFP EOC/COI as a guide, which is available upon request via email at HFPContract08@mrmib.ca.gov.

Deadlines

By **December 7, 2007**, email any changes to your 2007-08 EOC/COI that you want reflected in your 2008-09 EOC/COI along with a document summarizing the changes for approval to HFPContract08@mrmib.ca.gov.

By **April 2, 2008**, mail an updated Provider Directory to members and either a final 2008-09 EOC/COI or a letter describing the 2008-09 benefit changes. (NOTE: if you are sending a letter to your members describing the 2008-09 changes, MRMIB must approve the letter first)

By **June 13, 2008**, mail a final 2008-09 EOC/COI to your members, if you have not done so already.

By **July 3, 2008**, mail two (2) final, bound copies of your 2008-09 EOC/COI, one (1) electronic copy of your final EOC/COI on a CD, and one copy of your Provider Directory to MRMIB.

By **September 26, 2008**, mail a copy of the translated member packets to MRMIB.

All documents related to your 2008-09 EOC/COI submission should be sent to:

Managed Risk Medical Insurance Board
Attn: Willie Sanchez
1000 G Street, Suite 450
Sacramento, CA 95814

When e-mailing documents, please send them to: HFPContract08@mrmib.ca.gov.



Enclosure 5
Culture and Linguistic Services Report

CULTURAL AND LINGUISTIC SERVICES SURVEY
For Services in FY 2007-08

Plans should report in a multiple choice and narrative format (where indicated) the linguistically and culturally appropriate services provided and proposed to be provided to meet the needs of limited English proficient applicants and subscribers in the Healthy Families Program. Submission of this report fulfills the requirement in the 2005-08 contract for participating plans to submit a Cultural and Linguistic (C&L) report by December 10, 2007.¹

Submission Instructions

- Plans must submit their completed C&L Surveys to the Managed Risk Medical Insurance Board (MRMIB) **by December 10, 2007**.
- Documents must be submitted electronically to BQMmail@mrrib.ca.gov and should be compressed to 4 mgs or less and in a zipped file.

Note: Responses to all or part of the following questions may be made available to the public.

¹ Reference: HFP Contract 2005-08, Exhibit A, Item III.C.3.c.).



Enclosure 5
Culture and Linguistic Services Report

Plan Name: _____

I. Cultural and Linguistic Needs Assessment

1) How does the plan assess the Cultural and Linguistic needs of subscribers?

Check all that apply.

- a. ☐ Group Needs Assessment (GNA) annual update
- b. ☐ feedback from subscribers and subscriber representatives during plan meetings
- c. ☐ subscriber feedback from phone, mail or web surveys
- d. ☐ subscriber grievances and appeals
- e. ☐ encounter and claims data
- f. ☐ interpreter services utilization review
- g. ☐ other (explain):

II. Primary Care Physician Selection

2) When a subscriber has not selected a Primary Care Physician (PCP) what considerations does the plan take when using physician auto assignment?

Check all that apply.

- a. ☐ subscriber language preference
- b. ☐ language capabilities of provider office
- c. ☐ provider proximity the subscriber's home
- d. ☐ the plan does not require subscribers to select a PCP
- e. ☐ other (explain):

III. Identifying and Documenting Subscriber Language Preference

3) How does the plan identify the language preference of its subscribers?

Check all that apply.

- a. ☐ from HFP subscriber enrollment data
- b. ☐ during the welcome call
- c. ☐ other (explain):

4) How does the plan make providers aware of subscribers' language preferences?

Check all that apply.

- a. ☐ monthly subscriber eligibility reports with language preference
- b. ☐ new enrollee notification with language preference
- c. ☐ subscriber language preference is available to providers via the plan's secure web site
- d. ☐ the plan does not make providers aware of subscriber language preference
- e. ☐ other (explain):



Enclosure 5
Culture and Linguistic Services Report

- 5) Does the plan instruct providers in its network to record the language needs of subscribers?
- ☐ Yes, explain the process:
- ☐ No, explain:
- 6) Does the plan instruct providers to document in the medical record Requests/Refusals of language interpretive services?
- ☐ Yes, explain the process:
- ☐ No, explain:
- 7) How does the plan ensure providers comply with the items checked above?
- Check all that apply.
- a. ☐ train its providers on the need to document a request or refusal of interpreter services
- b. ☐ supply providers and their staff with Request/Refusal forms for interpreter services
- c. ☐ supply providers and their staff with chart labels identifying subscriber language needs
- d. ☐ implement an incentive program to reward provider offices that affirmatively attempt to identify language needs of LEP subscribers and record them on the medical charts (explain the program: _____)
- e. ☐ conduct reviews of providers' medical records during periodic audits and/or facility site reviews to check for documentation of the request for or refusal of interpreter services
- f. ☐ other (explain): _____

IV. Informing Subscribers of Interpretive Services

- 8) What methods does the plan utilize to inform its subscribers of the availability of no cost interpretive services?
- Check all that apply.
- a. ☐ welcome call/welcome letter
- b. ☐ evidence of coverage (EOC) or certificate of insurance (COI)
- c. ☐ other (explain): _____



Enclosure 5
Culture and Linguistic Services Report

9) What information does the plan provide to subscribers regarding interpreter services?

Check all that apply.

- a. ☐ availability of interpreter services to subscribers at no charge
- b. ☐ right not to use family subscribers, friends or minors as interpreters
- c. ☐ right to request an interpreter, during discussions of medical information such as diagnoses of medical conditions and proposed treatment options, and explanations of plans of care or other discussions with providers
- d. ☐ right to receive subscriber materials in the plan's threshold languages
- e. ☐ right to receive subscriber materials in alternative formats (Braille, large print, CD, DVD and oral translations)
- f. ☐ right to file a complaint or grievance if linguistic needs are not met
- g. ☐ other (please explain):

V. Provision of Interpretive Services

10) How does the plan provide 24 hour interpreter services to HFP subscribers?

Check all that apply.

- a. ☐ face-to-face interpreters
- b. ☐ telephone language line
- c. ☐ plan customer service (telephone/web system)
- d. ☐ other (explain):

11) Does the plan provide "Interpreter Request Cards" or "I Speak Cards"?

- ☐ Yes
- ☐ No

12) Are community based organizations (CBOs) used by the plan and/or subcontractor to interpret for subscribers?

- ☐ Yes (explain):
- ☐ No

13) Explain the process used by providers and subscribers to notify the plan when interpreter services are needed.

14) When has the provision of face-to-face interpreters not been feasible at medical points of contact?

15) The plan agrees that the use of family members or friends as interpreters shall not be required or encouraged. Explain the steps used by the plan and providers to encourage the use of qualified interpreters.



Enclosure 5
Culture and Linguistic Services Report

- 16) The plan also agrees that minors shall not be used as interpreters except for only the most extraordinary circumstances. Please describe any extraordinary circumstances when it was necessary to use minors as interpreters.

VI. Staff Education and Training

- 17) Explain the process utilized by the plan to inform/train plan staff and provider staff on:
- i. the plan's language assistance program
 - ii. cultural competency
- 18) The plan shall provide initial and continuing training on cultural competency to staff and providers. Please list training sessions for the 2007-08 benefit year (include title, date, duration, and goals):
- 19) How does the plan obtain evaluation/feedback on cultural competency training?
Check all that apply.
- a. ☐ post-training satisfaction surveys
 - b. ☐ discussion of training effectiveness at quality improvement meetings
 - c. ☐ other (please explain):

VII. Monitoring Language Assistance Services

- 20) How does the plan monitor its language assistance program (interpretive services)?
Check all that apply.
- a. ☐ feedback from subscribers and subscriber representatives during plan meetings
 - b. ☐ subscriber feedback from phone, mail or web surveys
 - c. ☐ findings from provider onsite audits conducted by the plan
 - d. ☐ review of subscriber grievances and appeals
 - e. ☐ review of encounter and claims data
 - f. ☐ interpreter services utilization review
 - g. ☐ other (explain):
- 21) How does the plan ensure subcontracted providers and/or vendors meet HFP cultural and linguistic services contractual requirements?
Explanation:



Enclosure 5
Culture and Linguistic Services Report

VIII. Points of Contact

22) At what non-medical and medical points of contact does the plan ensure language access for subscribers?

Check all that apply.

- a. ☐ during the appointment
- b. ☐ provider office reception
- c. ☐ appointment services phone or web site
- d. ☐ plan customer service
- e. ☐ subscriber orientation sessions
- f. ☐ health education classes
- g. ☐ other (please explain):

23) What methods are used by the plan to ensure language access at the points of contact checked above?

Check all that apply.

- a. ☐ hire staff with conversational fluency in multiple languages
- b. ☐ hire staff with bilingual fluency in medical terminology
- c. ☐ train staff to collect medical history data and respond to subscribers with culturally appropriate oral translations and forms
- d. ☐ provide interpreters with access to medical dictionaries/glossaries to use for accuracy in translation (i.e.; books; website; computer software)
- e. ☐ give plan/provider staff consistent interpreter training by experienced and properly trained interpreters
- f. ☐ periodically assess the language proficiency of the plan's identified medical and non-medical staff that have subscriber contact
- g. ☐ conduct audits of provider sites to confirm ongoing language capabilities of providers and staff
- h. ☐ other (explain):

IX. Provider Language Capabilities

24) Which tools does the plan use to report the on-site linguistic capabilities of providers and provider office staff to subscribers?

Check all that apply.

- a. ☐ written "hard" records
- b. ☐ electronic database
- c. ☐ provider directory
- d. ☐ website
- e. ☐ other (please explain):

25) How does the plan verify the proficiency of providers who indicate they are bilingual?
Explanation:



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Culture and Linguistic Services Report

X. Non-English Language Translations and Readability of Subscriber Materials

26) For each of the subscriber materials listed below, please list the non-English languages in which the plan translates the materials. Please note that the information provided will be included in comparative charts in the Healthy Families Program brochure or other public documents (Reference: HFP Contract, Exhibit A, Item III.C.2.a).

DOCUMENT	LANGUAGE/s
Evidence of Coverage or Certificate of Insurance	
Subscriber Handbook and information on how to use the subscriber handbook	
Welcome Letter	
Newsletters	
Preventive services reminders	
Health Education Material	
Letter and notices reducing, denying or terminating services or benefits (<i>Notice of Action</i>)	
Forms	
Patient satisfaction survey (ex: CAHPS)	
Notice of free language assistance	
Provider listings (directory)	
Marketing materials	
Complaints and grievance materials	
Any documents required by law or affecting any legal right or responsibility (ex: Disclosure and Consent Forms, etc.)	
Other (please describe):	

27) How does the plan ensure a sixth grade readability level for subscriber documents (including translated documents)?
Explanation:

XI. Translation Process

28) What is the plan's process for translation of documents?
Explanation:



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Culture and Linguistic Services Report

29) The plan agrees that the translation process shall include the use of qualified translators for translating and editing, proofreading and professional review. Which of the following activities does the plan undertake to ensure the quality of translated materials?

Check all that apply.

- a. ☐ contract and use of certified translation companies that follow a step-by-step translation process
- b. ☐ perform back translation of material into its source language for comparison and accuracy by certified translation vendors other than the original translator
- c. ☐ have an internal review committee that includes a medical and/or legal “professional reviewer” who reviews translated materials for cultural appropriateness
- d. ☐ proof-read and edit of documents by a separate qualified translation editor/proof reader
- e. ☐ use of computer technology as part of the process for producing culturally and linguistically appropriate translation
- f. ☐ other (please explain):

30) Which of the following activities does the plan use to ensure that subscribers who are unable to read the written materials that have been translated into non-English languages have an alternate form of access to the contents of the written materials?

Check all that apply.

- a. ☐ encourage subscribers to call the plan if they need help in understanding any of the plan’s written materials
- b. ☐ provide an oral translation of the material in a subscriber’s preferred language or arrange for this to be done by a competent interpreter service
- c. ☐ make the content of written materials available in alternative formats such as Braille, CD, and audio cassette
- d. ☐ other (please explain):

XII. Plan Internal Systems and Quality Improvement

31) Which of the following activities does the plan undertake in developing its internal systems to meet the cultural and linguistic needs of the subscribers?

Check all that apply.

- a. ☐ incorporate cultural competency in the plan's mission
- b. ☐ establish and maintain a process to evaluate and determine the need for special initiatives related to cultural competency
- c. ☐ develop recruitment and retention initiatives to establish organization-wide staffing that is reflective and/or responsive to the needs of the community
- d. ☐ assess the cultural competence of plan providers on a regular basis
- e. ☐ establish a special office or designated staff to coordinate and facilitate the integration of cultural competency guidelines
- f. ☐ distribute communication tools to staff relating to cultural competency issues (e.g., those tools generally used to distribute other operational policy-related issues)
- g. ☐ participate with government, community, and educational institutions in matters related to best practices in cultural competency in managed health care to ensure an outside perspective is maintained in plan policies
- h. ☐ maintain an information system capable of identifying and profiling cultural and linguistic specific patient data
- i. ☐ evaluate the effectiveness of strategies and programs in improving the health status of cultural-defined populations
- j. ☐ evaluate satisfaction feedback from subscriber surveys, staff, and/or providers
- k. ☐ evaluate encounter/claims data to improve services/processes
- l. ☐ evaluate input from subscriber advisory committees
- m. ☐ other

32) Explain any of the activities checked above.

33) As part of the plan's quality improvement efforts, does the plan utilize the following data to evaluate cultural and linguistic services and outcomes of cultural and linguistic activities?

Check all that apply.

- a. ☐ subscriber complaints and grievances
- b. ☐ results from subscriber satisfaction surveys
- c. ☐ utilization and other clinical data that may reveal health disparities as a result of cultural and linguistic barriers
- d. ☐ other (please explain):

34) For the items checked above, does the plan utilize primary language, race and ethnicity data to assess quality of care and monitor health disparities?

Explanation:



Enclosure 5
Culture and Linguistic Services Report

35) Has the plan implemented specific strategies or programs to address identified health disparities?

Explanation:

36) Attach the following cultural and linguistic related information

- a. A list of interpreter agencies used (including CBOs).
- b. Policies and Procedures for the plan's language assistance program.
- c. A list of the plan's threshold languages.

Highlight of Innovative Processes or Services:

Additional Comments:

PREPARER'S INFORMATION

Name and Title:

Mailing Address:

E-mail:

Phone #:

**California Healthy Families
Rating Sheets for Contract Year July 2008 through June 2009**

Instructions

Prepare a separate projection for each Healthy Families region in which you are submitting a bid. Highlighted cells containing certain key calculations are locked and cannot be modified.

Schedule 1: If applicable, provide historical utilization and costs for your Healthy Families Program (HFP) population by region, and for the state as a whole if your product is in more than one region. Provisions for incurred but not reported (IBNR) claims should be included in the reported figures, as appropriate. For each category of service, please provide the

- 1) Please provide the Healthy Families member months for the data period. This information is used in the calculated fields to derive the "Annual Utilization rate per 1,000 members" [**Column D**] and the "Gross Cost Per Unit of Service" [**Column E**].
- 2) **Column A:** a description of what the unit counts represent (for example, inpatient days, claims, units of service).
- 3) **Column B:** the total costs by service category
- 4) **Column C:** the total unit counts by service category
- 5) **Column D - Calculated Field:** The annual utilization rate per 1,000 members. This is calculated as units of service provided during the data period divided by the member months for the data period multiplied by 12,000.
- 6) **Column E - Calculated Field:** The gross cost per unit of service. This is calculated as total costs of service [**Column B**] divided by the total units of service [**Column C**] provided during the data period.
- 7) **Column F:** the average copay per unit of service. This should be calculated as the total copayments collected divided by the total units of service, within each category.
- 8) **Column G - Calculated Field:** the Net Cost Per Unit. This is calculated as the "Gross Cost per Unit" [**Column E**] minus the "Copay per Unit" entered in **Column F**.
- 9) **Column H - Calculated Field:** Cost PMPM. This is calculated by multiplying the "annual utilization rate per 1,000 members" [**Column D**] and the "net cost per unit" [**Column G**] and dividing the result by 12,000.

**California Healthy Families
Rating Sheets for Contract Year July 2008 through June 2009**

Instructions

Schedule 2: Using experience from the HFP provide projected trends and other adjustments for your HFP population by region. For 2008-2009, plans new to the HFP within the past 2 years should skip to Schedule 3B.

1) Enter your expected annual utilization and unit cost trend rates from the data period through the 2008-2009 contract period. For example, if you project Inpatient Hospital Med/Surg utilization will decrease by 5% per year and unit costs will increase by 10% per year, enter -5 and 10 in the Utilization and Unit Cost columns, respectively. The annual trend rate for per member per month costs is automatically calculated. The trend factors (the amount by which your reported experience will be adjusted for trend are also automatically calculated). If the appropriate number of trend months is different than 24, please enter the correct number and provide an explanation for the difference. The number of trend months should be from the midpoint of the experience period to the midpoint of the contract period (1/1/2009). Also, please provide an explanation of the source of your trend assumptions in the space provided.

2) As appropriate, enter any additional adjustment factors to be applied to project historical costs to the contract period. These factors will be automatically applied to the historical utilization rates to produce the projected utilization in Schedule 3A. Provide a brief description of the reason for the adjustments next to the factor. Further space is provided at the bottom of the schedule if necessary to adequately describe the nature of the adjustments.

Schedule 3A: This schedule develops the expected 2008-2009 health care costs for the HFP population in each region. Schedule 3A is automatically populated using the reported experience and the assumptions in Schedule 2.

Schedule 3B: Complete this schedule only if your plan was new to HFP within the past two years. You may use data other than HFP experience for the rate development process. Identify the data source for the utilization and cost assumptions. As in Schedule 1, enter the utilization, unit cost, and copayment assumptions in **columns (A), (B), (C), (F). Columns (D), (E), (G), (H)** are calculated fields. The unadjusted health care cost will be automatically calculated. Make the adjustments in Schedule 3C.

**California Healthy Families
Rating Sheets for Contract Year July 2008 through June 2009**

Instructions

Schedule 3C: If Schedule 3B was completed, calculate the following adjustments and enter in Schedule 3C. The adjusted health care cost will be automatically calculated.

- A. Identify the adjustment made to reflect the nominal number of newborns likely to be covered by the program. Medi-Cal covers most newborns in families with incomes up to 200% of FPL. Infants above 200% are covered in a separate HFP rate for health plans which MRMIB will calculate based on data in house.
- B. Identify the adjustment made to reflect the nominal level of maternity services that are likely to be required.
- C. Identify the adjustment made to reflect that health plans are not responsible for covering the costs of California Children's Services conditions.
- D. Identify the adjustment made to reflect that community mental health departments provide mental health services to children defined as having a serious emotional disturbance.

Schedule 4: Report administrative costs per member per month for the HFP in the categories shown. Enter your projected health care costs from Schedule 3A or Schedule 3C, as appropriate. Schedule 4 calculates the projected rate as the sum of the administrative costs and the projected health care costs.

Schedules 5 and 6: Complete the loss ratio report. Include all incentives and risk sharing payments. Provide a description at the bottom of Schedule 6. Do not include any funds for Rural Health Demonstration Project, only include capitation paid to you from the Managed Risk Medical Insurance Board. For current HFP plans, the expenses reported on Line 17 (TOTAL MEDICAL AND HOSPITAL) of Schedule 7 should be equivalent to the Total Health Care Expenditures calculated at the bottom of Schedule 1. should be a consolidation for all regions. Also, this Schedule 6 and 7 should be in the workbook for the first region that your plan is submitting a projection for (ie. If your plan is submitting for Regions 1 through 6, then the consolidated Schedule 6 and 7, will be in the workbook for Region 1).

Schedule 6A: Complete the loss ratio report for the current year, through November 2007 and include IBNR for this period on line 15.

Schedule 7: Fill out this schedule if your loss ratio is below your contractual level. The schedule asks for an explanation if the loss ratio is below the contractual level and for a description of the methods you intend to use to reach your target loss ratio.

**California Healthy Families
Rating Sheets for Contract Year July 2008 through June 2009**

Instructions

Schedules 8A and 8B: This is a presentation of your rate projection and must equal the Schedule 4 Line 25 & 26.

Schedule 9:

Part A - Report your plan's members by payor at the end of December 31, 2007.

Part B - Report the compensation paid each provider type by basis of payment. (For example: capitation, per diem, salary.)

Schedule 10: Answer the questions regarding your healthplan's incentive payment and pay for performance programs.

Schedule 11: Provide a certification by your health plan's actuary that the experience for 2006-2007 is accurate and that the assumptions used to project costs during the contract period are reasonable.

Submit Schedules 1 through 11 via e-mail to HFPRates08-09@mrmib.ca.gov by close of business 1/4/08. Mail a signed copy of Schedule 11 (Actuarial Certification) to Ms. Jackie Baker c/o MRMIB, 1000 G St. Suite 450, Sacramento, CA 95814, by 1/11/08.

California Healthy Families
July 2008 - June 2009 Rate Development
Utilization and Cost Experience July 2006 through June 2007
Fill out one for each Region and Statewide (if applicable)

Schedule 1

Plan Name _____

(Specify Region or Statewide) _____

HFP Member Months July 2006 - June 2007

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
	Description of Units (e.g., days, claims, units of service)	Total Cost	Total Units	Annual Units per 1000 Members	Gross Cost per Unit	Copay per Unit	Net Cost per Unit	Cost PMPM
Health care services								
Inpatient Hospital								
Med/Surg					\$ -		\$ -	\$ -
Maternity					\$ -		\$ -	\$ -
Newborn					\$ -		\$ -	\$ -
Mental Health					\$ -		\$ -	\$ -
Chemical Dependency					\$ -		\$ -	\$ -
Abortion - Federally sponsored (1)					\$ -		\$ -	\$ -
Abortion - State sponsored (2)					\$ -		\$ -	\$ -
Rehab Care & SNF					\$ -		\$ -	\$ -
Capitation								
Provider Incentive Payments								
Total								\$ -
Outpatient Hospital & Surgical Center								
Emergency Room					\$ -		\$ -	\$ -
Clinic					\$ -		\$ -	\$ -
Mental Health					\$ -		\$ -	\$ -
Chemical Dependency					\$ -		\$ -	\$ -
Abortion - Federally sponsored (1)					\$ -		\$ -	\$ -
Abortion - State sponsored (2)					\$ -		\$ -	\$ -
Capitation								
Provider Incentive Payments								
Total								\$ -
Professional								
Well baby/child					\$ -		\$ -	\$ -
Immunizations/injections					\$ -		\$ -	\$ -
Physician office visits					\$ -		\$ -	\$ -
Surgery					\$ -		\$ -	\$ -
Mental Health					\$ -		\$ -	\$ -
Chemical Dependency					\$ -		\$ -	\$ -
Abortion - Federally sponsored (1)					\$ -		\$ -	\$ -
Abortion - State sponsored (2)					\$ -		\$ -	\$ -
Capitation								
Provider Incentive Payments								
Total								\$ -
Chiropractic/Acupuncture					\$ -		\$ -	\$ -

California Healthy Families
July 2008 - June 2009 Rate Development
Utilization and Cost Experience July 2006 through June 2007
Fill out one for each Region and Statewide (if applicable)

Schedule 1

Plan Name _____

(Specify Region or Statewide) _____

HFP Member Months July 2006 - June 2007

Health care services

Ancillary Services

(A) Description of Units (e.g., days, claims, units of service)	(B) Total Cost	(C) Total Units	(D) Annual Units per 1000 Members	(E) Gross Cost per Unit	(F) Copay per Unit	(G) Net Cost per Unit	(H) Cost PMPM
---	-------------------	--------------------	--	-------------------------------	--------------------------	-----------------------------	------------------

Home Health (Including Hospice)

Diagnostic x-ray/lab

DME & Supplies

Physical & Occupational Therapy

Speech Therapy

Prescription drugs

Other

Capitation

Net Reinsurance Costs

UM/QA Costs

Total

				\$ -		\$ -	\$ -
				\$ -		\$ -	\$ -
				\$ -		\$ -	\$ -
				\$ -		\$ -	\$ -
				\$ -		\$ -	\$ -
				\$ -		\$ -	\$ -
				\$ -		\$ -	\$ -
							\$ -

Provider Incentive Payments

Grand total excluding Provider Incentive Payments

Grand total including Provider Incentive Payments

\$ -
\$ -
\$ -

Total Health Care Expenditures

\$0

(1) Federally sponsored abortion is necessary due to rape, incest and to save the life of the mother.

(2) State sponsored abortion is all other than Federally sponsored.

California Healthy Families

July 2008 - June 2009 Rate Development

Assumptions used to project costs for July 2008 - June 2009

Fill out one for each Region

Schedule 2

Plan Name _____

Specify Region _____

Months of Trend (should be 24 if data from 2006/2007 contract year used as the base):

If different than 24, please explain: _____

Health care services

Inpatient Hospital

	Annualized Trend Rates			Trend Factors			Other Adjustments	
	Utilization	Unit Cost	PMPM	Utilization	Unit Cost	PMPM	Factors	Description
Med/Surg			0.00%	1.000	1.000	1.000	1.000	
Maternity			0.00%	1.000	1.000	1.000	1.000	
Newborn			0.00%	1.000	1.000	1.000	1.000	
Mental Health			0.00%	1.000	1.000	1.000	1.000	
Chemical Dependency			0.00%	1.000	1.000	1.000	1.000	
Abortion - Federally Sponsored (1)			0.00%	1.000	1.000	1.000	1.000	
Abortion - State Sponsored (2)			0.00%	1.000	1.000	1.000	1.000	
Rehab Care & SNF			0.00%	1.000	1.000	1.000	1.000	
Capitation						1.000	1.000	
Provider Incentive Payments						1.000	1.000	
Total								

Outpatient Hospital & Surgical Center

Emergency Room			0.00%	1.000	1.000	1.000	1.000	
Clinic			0.00%	1.000	1.000	1.000	1.000	
Mental Health			0.00%	1.000	1.000	1.000	1.000	
Chemical Dependency			0.00%	1.000	1.000	1.000	1.000	
Abortion - Federally Sponsored (1)			0.00%	1.000	1.000	1.000	1.000	
Abortion - State Sponsored(2)			0.00%	1.000	1.000	1.000	1.000	
Capitation						1.000	1.000	
Provider Incentive Payments						1.000	1.000	
Total								

Professional

Well baby/child			0.00%	1.000	1.000	1.000	1.000	
Immunizations/injections			0.00%	1.000	1.000	1.000	1.000	
Physician office visits			0.00%	1.000	1.000	1.000	1.000	
Surgery			0.00%	1.000	1.000	1.000	1.000	
Mental Health			0.00%	1.000	1.000	1.000	1.000	
Chemical Dependency			0.00%	1.000	1.000	1.000	1.000	
Abortion - Federally Sponsored (1)			0.00%	1.000	1.000	1.000	1.000	
Abortion - State Sponsored (2)			0.00%	1.000	1.000	1.000	1.000	
Capitation						1.000	1.000	
Provider Incentive Payments						1.000	1.000	
Total								

California Healthy Families
July 2008 - June 2009 Rate Development
Assumptions used to project costs for July 2008 - June 2009
Fill out one for each Region

Schedule 2

Plan Name _____

Specify Region _____

Months of Trend (should be 24 if data from 2006/2007 contract year used as the base):

If different than 24, please explain: _____

Health care services

Ancillary Services

Home Health (Including Hospice)
Diagnostic x-ray/lab
DME & Supplies
Physical & Occupational Therapy
Speech Therapy
Prescription drugs
Other
Capitation
Net Reinsurance Costs
UM/QA Costs
Total

Annualized Trend Rates		
Utilization	Unit Cost	PMPM

		0.00%
		0.00%
		0.00%
		0.00%
		0.00%
		0.00%
		0.00%

Trend Factors		
Utilization	Unit Cost	PMPM

1.000	1.000	1.000
1.000	1.000	1.000
1.000	1.000	1.000
1.000	1.000	1.000
1.000	1.000	1.000
1.000	1.000	1.000
1.000	1.000	1.000
		1.000
		1.000
		1.000

Other Adjustments	
Factors	Description

1.000	
1.000	
1.000	
1.000	
1.000	
1.000	
1.000	
1.000	
1.000	
1.000	

Grand total

- (1) Federally sponsored abortion is necessary due to rape, incest and to save the life of the mother.
(2) State sponsored abortion is all other than Federally sponsored.

Source of trend assumptions:

Other Adjustments:

California Healthy Families
July 2008 - June 2009 Rate Development
Projected Health Care Costs for July 2008 - June 2009
Based on Healthy Families Experience Projection
Fill out one for each Region

Schedule 3A

Plan Name _____

Specify Region _____

	(A)	(B)	(C)	(D)	(E)
Health care services	Annual Units per 1000 Members	Gross Cost per Unit	Copay per Unit	Net Cost per Unit	Cost PMPM
Inpatient Hospital					
Med/Surg		\$ -	\$ -	\$ -	\$ -
Maternity		\$ -	\$ -	\$ -	\$ -
Newborn		\$ -	\$ -	\$ -	\$ -
Mental Health		\$ -	\$ -	\$ -	\$ -
Chemical Dependency		\$ -	\$ -	\$ -	\$ -
Abortion - Federally Sponsored (1)		\$ -	\$ -	\$ -	\$ -
Abortion - State Sponsored (2)		\$ -	\$ -	\$ -	\$ -
Rehab Care & SNF		\$ -	\$ -	\$ -	\$ -
Capitation					\$ -
Provider Incentive Payments					\$ -
Total					\$ -
Outpatient Hospital & Surgical Center					
Emergency Room		\$ -	\$ -	\$ -	\$ -
Clinic		\$ -	\$ -	\$ -	\$ -
Mental Health		\$ -	\$ -	\$ -	\$ -
Chemical Dependency		\$ -	\$ -	\$ -	\$ -
Abortion - Federally Sponsored (1)		\$ -	\$ -	\$ -	\$ -
Abortion - State Sponsored (2)		\$ -	\$ -	\$ -	\$ -
Capitation					\$ -
Provider Incentive Payments					\$ -
Total					\$ -
Professional					
Well baby/child		\$ -	\$ -	\$ -	\$ -
Immunizations/injections		\$ -	\$ -	\$ -	\$ -
Physician office visits		\$ -	\$ -	\$ -	\$ -
Surgery		\$ -	\$ -	\$ -	\$ -
Mental Health		\$ -	\$ -	\$ -	\$ -
Chemical Dependency		\$ -	\$ -	\$ -	\$ -
Abortion - Federally Sponsored (1)		\$ -	\$ -	\$ -	\$ -
Abortion - State Sponsored (2)		\$ -	\$ -	\$ -	\$ -
Capitation					\$ -
Provider Incentive Payments					\$ -
Total					\$ -
Chiropractic/Acupuncture		\$ -	\$ -	\$ -	\$ -

California Healthy Families
July 2008 - June 2009 Rate Development
Projected Health Care Costs for July 2008 - June 2009
Based on Healthy Families Experience Projection
Fill out one for each Region

Schedule 3A

Plan Name _____

Specify Region _____

	(A)	(B)	(C)	(D)	(E)
Health care services	Annual Units per 1000 Members	Gross Cost per Unit	Copay per Unit	Net Cost per Unit	Cost PMPM
Ancillary Services					
Home Health (Including Hospice)		\$ -	\$ -	\$ -	\$ -
Diagnostic x-ray/lab		\$ -	\$ -	\$ -	\$ -
DME & Supplies		\$ -	\$ -	\$ -	\$ -
Physical & Occupational Therapy		\$ -	\$ -	\$ -	\$ -
Speech Therapy		\$ -	\$ -	\$ -	\$ -
Prescription drugs		\$ -	\$ -	\$ -	\$ -
Other		\$ -	\$ -	\$ -	\$ -
Capitation					\$ -
Net Reinsurance Costs					\$ -
UM/QA Costs					\$ -
Total					\$ -
Grand total including Provider Incentive Payments					\$ -
Provider Incentive Payments					\$ -
Grand total excluding Provider Incentive Payments					\$ -

- (1) Federally sponsored abortion is necessary due to rape, incest and to save the life of the mother.
(2) State sponsored abortion is all other than Federally sponsored.

California Healthy Families
July 2008 - June 2009 Rate Development
Projected costs for July 2008 - June 2009
New Plans (in Healthy Families 2 years or less)
Fill out one for each Region

Plan Name _____

Specify Region _____

Data source for developing assumptions [e.g., Commercial, Other (describe)]: _____

Member Months July 2006 - June 2007

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
	Description of Units (e.g., days, claims, units of service)	Total Costs	Total Units	Annual Units per 1000 Members	Gross Cost per Unit	Copay per Unit	Net Cost per Unit	Cost PMPM
Health care services								
Inpatient Hospital								
Med/Surg					\$ -		\$ -	\$ -
Maternity					\$ -		\$ -	\$ -
Newborn					\$ -		\$ -	\$ -
Mental Health					\$ -		\$ -	\$ -
Chemical Dependency					\$ -		\$ -	\$ -
Abortion - Federally Sponsored (1)					\$ -		\$ -	\$ -
Abortion - State Sponsored (2)					\$ -		\$ -	\$ -
Rehab Care & SNF					\$ -		\$ -	\$ -
Capitation								
Provider Incentive Payments								
Total								\$ -
Outpatient Hospital & Surgical Center								
Emergency Room					\$ -		\$ -	\$ -
Clinic					\$ -		\$ -	\$ -
Mental Health					\$ -		\$ -	\$ -
Chemical Dependency					\$ -		\$ -	\$ -
Abortion - Federally Sponsored (1)					\$ -		\$ -	\$ -
Abortion - State Sponsored (2)					\$ -		\$ -	\$ -
Capitation								
Provider Incentive Payments								
Total								\$ -
Professional								
Well baby/child					\$ -		\$ -	\$ -
Immunizations/injections					\$ -		\$ -	\$ -
Physician office visits					\$ -		\$ -	\$ -
Surgery					\$ -		\$ -	\$ -
Mental Health					\$ -		\$ -	\$ -
Chemical Dependency					\$ -		\$ -	\$ -
Abortion - Federally Sponsored (1)					\$ -		\$ -	\$ -
Abortion - State Sponsored (2)					\$ -		\$ -	\$ -
Capitation								
Provider Incentive Payments								
Total								\$ -
Chiropractic/Acupuncture					\$ -		\$ -	\$ -

California Healthy Families
July 2008 - June 2009 Rate Development
Projected costs for July 2008 - June 2009
New Plans (in Healthy Families 2 years or less)
 Fill out one for each Region

Specify Region

Member Months July 2006 - June 2007

(1) Federally sponsored abortion is necessary due to rape, incest and to save the life of the mother.
(2) State sponsored abortion is all other than Federally sponsored.

ENCLOSURE 8 - PART A
Health RDT 2008-09
Schedule 3B
10/24/2007

California Healthy Families
July 2008 - June 2009 Rate Development
Projected costs for July 2008 - June 2009
New Plans (in Healthy Families 2 years or less)

Schedule 3C

Plan Name _____

(Specify Region or Statewide) _____

Health care services

Adjustments:

- Reduction for 0 - 1 year olds *
- Reduction for maternity *
- Reduction for California Children's Services
- Reduction for Community Mental Health Services

Cost PMPM

Total health care costs after adjustments

\$ -

* Maternity and newborn services will generally be provided by this program only when the mother is a program participant prior to becoming pregnant or infants from 200% to 250% fpl for which there is a separate health rate.

California Healthy Families
July 2008 - June 2009 Rate Development
Projected costs for July 2008 - June 2009
Administrative Costs and Rate Projection

Schedule 4

Plan Name _____

Specify Region _____

Administrative costs

Claims processing, data processing, customer service

General administrative overhead

Marketing: Communication, education, printing

Provider contracting, managed care network maintenance

Risk charges (identify) _____

Profit

Other (identify) _____

Total administrative costs

Total health care costs from Schedule 3A or 3C

Total health care costs plus administrative costs (total per member per month premium)

Rate projection excluding State sponsored Abortions

Rate projection for State Sponsored Abortions

Cost PMPM	Percent of premium
-----------	--------------------

	0.00%
	0.00%
	0.00%
	0.00%
	0.00%
	0.00%
	0.00%

\$ -	0.00%
\$ -	0.00%
\$ -	0.00%

\$ -	0.00%
\$ -	0.00%

HEALTHY FAMILIES PROGRAM
July 2008 - June 2009 Rate Development
7/06 - 6/07 LOSS RATIO REPORT

Schedule 5

Plan Name _____

Did your plan have a minimum 1,000 HFP enrolled subscribers per month for six of more months in the July 06 - June 07 benefit year?

Yes
No

NOTE: All Plans, regardless of enrollment must complete the loss ratio report.

Total \$ amount of covered benefits for services provided to HFP subscribers from 7/1/06 - 6/30/07*

\$	-
----	---

Total \$ amount of premiums received from the state for HFP subscribers from 7/1/06 - 6/30/07 **

\$	-
----	---

Total \$ amount of incentive payments made from 7/1/06 - 6/30/07

\$	-
----	---

Healthy Families Program 7/1/06 - 6/30/07 Benefit Year Actual Loss Ratio excluding Incentive Payments

(Sch. 6: Item 17/ Item 1)

0.00%

Healthy Families Program 7/1/06 - 6/30/07 Benefit Year Actual Loss Ratio including Incentive Payments

(Sch. 6: Item 4 plus 17/ item 1)

0.00%

Healthy Families Program 7/1/06 - 6/30/07 Benefit Year Minimum Loss Ratio in Contract

--

Difference between Actual Loss Ratio without Incentive Payment above and Minimum Loss Ratio in Contract

0.00%

Difference between Actual Loss Ratio with Incentive Payment above and Minimum Loss Ratio in Contract

0.00%

Interim loss ratio from Schedule 6A

0.00%

* Total from Item # **17** on the Statement of Revenue and Expenses Report, Schedule 6

** Total from Item # **1** on the Statement of Revenue and Expenses Report, Schedule 6

If your plan's **Actual Loss Ratio** is lower than the **Minimum Loss Ratio in Contract**, complete the Loss Ratio Description Schedule 7

Schedule 6

HEALTHY FAMILIES PROGRAM 2006-2007 LOSS RATIO REPORT STATEMENT OF REVENUE AND EXPENSES

Plan Name _____ Healthy Families Benefit Year
July 1, 2006 - June 30, 2007

SUBSCRIBER MONTHS (Healthy Families Program subscribers only) _____

1. Premium Payments from State	
--------------------------------	--

AFFILIATED ENTRIES AND NONAFFILIATED ENTRIES:

2. Incentive Payments to affiliated parties, including any risk sharing payments	
3. Incentive Payments by to nonaffiliated parties, including risk sharing payments	
4. Total Incentive Payments	\$ -

EXPENSES: (Healthy Families Program only)

Medical and Hospital:

5. Inpatient Services - Capitated	
6. Inpatient Services - Per Diem	
7. Inpatient Services - Fee-for-service/Case Rate	
8. Primary Professional Services - Capitated	
9. Primary Professional Services - Non-Capitated	
10. Other Medical Professional Services - Capitated	
11. Other Medical Professional Services - Non-Capitated	
11. Non-Contracted Emergency Room and Out-of-Area Expense, not including POS	
13. POS Out-of-Network Expense	
14. Pharmacy Expense	
15. Other Medical Expense	
16. Aggregate Write-ins for Other Medical and Hospital Expense	
17. TOTAL MEDICAL AND HOSPITAL (Line 5 to Line 16)	\$ -

Administration:

18. Compensation	
19. Interest Expense	
20. Occupancy, Depreciation and Amortization	
21. Management Fees	
22. Marketing	
23. Affiliate Administration Services	
24. Aggregate Write-ins for Other Administration Expenses	
25. TOTAL ADMINISTRATION (Line 18 to Line 24)	\$ -
26. TOTAL EXPENSES (Lines 4, 17, and 25)	\$ -
27. INCOME/(LOSS) (Line 1 less Line 26)	\$ -
28. Extraordinary Item	
29. Provision for Taxes	
30. NET INCOME/(LOSS) (Line 27 plus Lines 28 & 29)	\$ -

Line 17 TOTAL MEDICAL AND HOSPITAL EXPENSE	\$ -
Schedule 1 Total Health Care Expenditures	\$ -
Difference	\$ -

Explain any differences _____

Schedule 6A

HEALTHY FAMILIES PROGRAM July 2008 - June 2009 Rate Development Interim Statement of Revenue & Expenses

PLAN NAME _____

Total Capitation Payments Received July 2007 through November 2007

PLAN CAPITATION RECEIVED

AFFILIATED ENTRIES AND NONAFFILIATED ENTRIES:

1. Incentive Payments to affiliated parties	
2. Incentive Payments by to nonaffiliated parties.	
3. Total Incentive Payments	

EXPENSES: (Healthy Families Program only)

Medical and Hospital:

4. Inpatient Services - Capitated	
5. Inpatient Services - Per Diem	
6. Inpatient Services - Fee-for-service/Case Rate	
7. Primary Professional Services - Capitated	
8. Primary Professional Services - Non-Capitated	
9. Other Medical Professional Services - Capitated	
10. Other Medical Professional Services - Non-Capitated	
11. Non-Contracted Emergency Room and Out-of-Area Expense, not including POS	
12. POS Out-of-Network Expense	
13. Pharmacy Expense	
14. Other Medical Expense	
15. Estimated IBNR	
16. Aggregate Write-ins for Other Medical and Hospital Expense	
17. TOTAL MEDICAL AND HOSPITAL (<i>Line 4</i> to <i>Line 16</i>)	

INTERIM LOSS RATIO

0.00%

HEALTHY FAMILIES PROGRAM 2006-2007 LOSS RATIO REPORT

Plan Name _____

If your plan's Actual Loss Ratio is lower than your Minimum Loss Ratio in Contract, provide a detailed response explaining 1) why the actual loss ratio was significantly below the contractual standard and 2) plans you have to assure the Board that future loss ratios will be consistent with the contractual standard agreed to in your contract. Please respond to the following specific questions. Your response can be provided in a separate file if you prefer.

1. Why is your company's actual loss ratio substantially lower than the projected value for the 2006-2007 benefit year?

2. How do your HFP provider payments to each segment of the provider community (primary care physicians, clinics, medical groups, specialty physicians, and hospitals) compare to your contractual payments in:

- The MediCal Program?
- Commercial products?
- The payment schedules set forth in the Medicare program?

3. How does your company's HFP utilization experience in each of the major service categories (physician services, pharmaceuticals, inpatient care) compare to your company's children's utilization experience in:

- The MediCal Program?
- Commercial products?

4. Does your plan offer providers any type of "end of year" payment incentive program? If so, please describe. Include in your description any differences in the allocation of incentive payments to affiliated and non-affiliated groups or other distinctions in how incentive payments are made by group.

5. What does your plan do to encourage families to seek out and utilize preventive services such as immunizations and well child visits? Do you have plans to improve provider's behavior with regard to providing and reporting appropriate preventive care visits? If so, please describe.

6. Are there other factors that explain your plan's low loss ratio? If yes, please describe.

7. What are the methods you will use to reach your target loss ratio?
When would you expect that to occur?

8. [For current year interim loss ratio data only]: Please comment as appropriate.

Schedule 8A

Healthy Families Program
Contract No. _____

Confidential Attachment

Rates of Payment
Page ____ of ____

PREMIUM RATES - INCLUDING FEDERALLY SPONSORED ABORTIONS*

Note: Projection should match the figure shown in Schedule 4.

	Geographic Area 1	Geographic Area 2	Geographic Area 3	Geographic Area 4	Geographic Area 5	Geographic Area 6
Per Subscriber age 1 to 18 years of age						

* Federally sponsored abortion is necessary due to rape, incest and to save the life of the mother.

PREMIUM RATES - STATE SPONSORED ABORTIONS*

Note: Projection should match the figure shown in Schedule 4.

	Geographic Area 1	Geographic Area 2	Geographic Area 3	Geographic Area 4	Geographic Area 5	Geographic Area 6
Per Subscriber age 1 to 18 years of age						

* State sponsored abortion is all other than Federally sponsored.

HEALTHY FAMILIES PROGRAM
July 2008 - June 2009 Rate Development
Program and Provider Type Detail for Dec 31, 2006 to Dec 31, 2007

Schedule 9

Plan Name: _____

Part A

	31-Dec-06		31-Dec-07	
	Total Employees	Total Members	Total Employees	Total Members
Individual Market				
Small Group Market (2-50)				
Large Group Market (51+)				
Medi-Cal				
Medicare				
Other (Please Specify)				
All California Business				

Part B

The physician and hospital compensation during 2006-2007 for the Healthy Families Program			
	PCP Providers	Specialist Providers	Hospitals
Capitation	<u>0.00%</u>	<u>0.00%</u>	<u>0.00%</u>
Fee Schedule	<u>0.00%</u>	<u>0.00%</u>	<u>0.00%</u>
Salary	<u>0.00%</u>	<u>0.00%</u>	<u>0.00%</u>
Combination	<u>0.00%</u>	<u>0.00%</u>	<u>0.00%</u>
Total per provider type	<u>0.00%</u>	<u>0.00%</u>	<u>0.00%</u>

HEALTHY FAMILIES PROGRAM
July 2008 - June 2009 Rate Development
Provider Incentive and Pay for Performance Programs

Schedule 10

Plan Name: _____

Please provide your answers to the following questions on a separate sheet.

General

1. Does your healthplan use incentive payments or pay for performance components in contracts with providers for any of your lines of business, including Healthy Families?
2. If the answer to Question 1 is no, do you have plans to add these components in the future? If yes, please describe the expected structure of the program and anticipated implementation date.

If your answers to Questions 1 and 2 are "No", you are finished with this Schedule

3. How long has your healthplan used incentive payments or pay for performance programs in its contracts with providers? If different systems have been in place for different periods of time, please indicate the length of time for each system.
4. Please describe the incentive or pay for performance programs you have in place, including the criteria used to determine payment amounts. If you use more than one system, please describe each and indicate which is the predominant system. Also, please indicate the system in place for your Healthy Families business. If the measurement criteria is different for your Healthy Families business versus your non-Healthy Families business, please describe how it differs.
5. Please describe the types and percentages of providers eligible for these payments and the actual percentage of each provider type receiving such payments.
6. Depending on how your program is structured, please describe the percentage of total compensation or percentage increase in base compensation can be earned as a result of incentive payments or payments for performance.

Healthy Families Expenditure Data for July 2006 - June 2007

7. Did your plan include amounts related to provider incentive payments or pay for performance in the cost information shown in Schedule 1?

If the answer to this question is "No", proceed to next section.

8. Do the amounts summarized in Row 66 of Schedule 1 include all costs related to incentive payments or pay for performance? If no, please provide the additional amounts and describe how they differ from the amounts reported in Row 66.
9. Please describe the criteria upon which the determination of all incentive payments and payments for performance were made. Please be specific.

Healthy Families Proposed Rates for July 2008 - June 2009

10. Do the rates you proposed for the July 2008 - June 2009 benefit period include incentive or pay for performance components?

If your answers to this question is "No", you are finished with this Schedule

11. Please provide the percentage of your proposed July 2008 - June 2009 Healthy Families premium associated with expected incentive payments or payment for performance.
12. Please describe how you estimated the incentive payment or pay for performance amounts included in these premium rates.
13. Describe the criteria upon which the determination of incentive payments or payment for performance is expected to be determined during the July 2008 - June 2009 rate period. Please be specific.

California Healthy Families
July 2008 - June 2009 Rate Development
Projected costs for July 2008 - June 2009 and Loss Ratio Report
Certification

Schedule 11

Plan Name _____

I certify that the claims experience and cost projections are accurate and appropriate for the California Healthy Families Program.

By: _____
Print name Date

Signature & Title Phone number

California Healthy Families
Infant Rate Development - First 60 Days of Life
July 2008 - June 2009 Rate Development

Instructions

Prepare a separate projection for each Healthy Families region in which you are submitting a bid. Highlighted cells containing certain key calculations are locked and cannot be modified.

Instructions

Schedules 1: Provide historical utilization and costs for an infant's **first 60 days of life**. Use data that you believe is credible and reasonably consistent with expected experience under HFP. Schedule 2 provides a means for adjustment to expected HFP utilization and cost levels. Provisions for incurred but not reported (IBNR) claims should be included in the reported figures. Please specify which line of business the experience basis reflects [AIM, Commercial business, or Medi-Cal] as applicable to your plan. In addition, for each category of service, please provide the following:

- 1) Please provide member months associated with the infants' first 60 days of life for the data period. The remainder of the values are automatically calculated. This information is used in the calculated fields to derive the "Annual Utilization rate per 1,000 members" [**Column D**] and the "Gross Cost Per Unit of Service" [**Column E**].
- 2) **Column A:** a description of what the unit counts represent (for example, inpatient days, claims, units of service).
- 3) **Column B:** the total costs by service category
- 4) **Column C:** the total unit counts by service category
- 5) **Column D - Calculated Field:** The annual utilization rate per 1,000 members. This is calculated as units of service provided during the data period divided by the member months for the data period multiplied by 12,000.
- 6) **Column E - Calculated Field:** The gross cost per unit of service. This is calculated as total costs of service [**Column B**] divided by the total units of service [**Column C**] provided during the data period.
- 7) **Column F:** the average copay per unit of service. This should be calculated as the total copayments collected divided by the total units of service, within each category.
- 8) **Column G - Calculated Field:** the Net Cost Per Unit. This is calculated as the "Gross Cost per Unit" [**Column E**] minus the "Copoly per Unit" entered in **Column F**.
- a) **Column H - Calculated Field:** Cost BMPM. This is calculated by multiplying the

California Healthy Families
Infant Rate Development - First 60 Days of Life
July 2008 - June 2009 Rate Development

Instructions

Prepare a separate projection for each Healthy Families region in which you are submitting a bid. Highlighted cells containing certain key calculations are locked and cannot be modified.

Instructions

- 3) The net cost of reinsurance. This equals reinsurance premiums less reinsurance recoveries. The figures in the detail lines should be reported before reinsurance recoveries are taken into account.
- 4) Utilization management and quality assurance (UM/QA) costs.

Schedule 2: Provide projected trends and other adjustments to reflect your expected **first 60 days of life** experience under the HFP program.

1) Enter your expected annual utilization and unit cost trend rates from the data period through the 2008-2009 contract period. For example, if you project Inpatient Hospital Med/Surg utilization will decrease by 5% per year and unit costs will increase by 10% per year, enter -5 and 10 in the Utilization and Unit Cost columns, respectively. The annual trend rate for per member per month costs is automatically calculated. The trend factors (the amount by which your reported experience will be adjusted for trend are also automatically calculated). If the appropriate number of trend months is different than 24, please enter the correct number and provide an explanation for the difference. The number of trend months should be from the midpoint of the experience period to the midpoint of the contract period (1/1/2009). Also, please provide an explanation of the source of your trend assumptions in the

2) As appropriate, enter any additional adjustment factors to be applied to reflect expected costs for HFP infant in their **first 60 days of life** during in the contract period. These factors will be automatically applied to the historical utilization rates to produce the projected utilization in Schedule 3A. Provide a brief description of the reason for the adjustments next to the factor. Further space is provided at the bottom of the schedule if necessary to adequately describe the nature of the adjustments.

Schedule 3A: This schedule develops the expected 2008-2009 health care costs for HFP infants in their **first 60 days of life** in each region. Schedule 3A is automatically populated using the reported experience and the assumptions in Schedule 2.

Schedule 3B: Provide the expected per member per month value of California Children's Services coverage for HFP infants in their **first 60 days of life**.

California Healthy Families
Infant Rate Development - First 60 Days of Life
July 2008 - June 2009 Rate Development

Instructions

Prepare a separate projection for each Healthy Families region in which you are submitting a bid. Highlighted cells containing certain key calculations are locked and cannot be modified.

Instructions

Schedule 4: Provide administrative costs per member per month related to HFP infants in their **first 60 days of life** for the categories shown. Your projected health care costs from Schedule 3B will automatically be carried forward. Schedule 4 calculates the projected rate as the sum of the administrative costs and the projected health care costs. This rate represents your proposed payment rate for HFP infants in their **first 60 days of life**.

Schedule 5: Provide a distribution of payments the **first 60 days of life** for the line of business specified in Schedule 1. The total payments in these schedules should match the total expenditures from Schedule 1, with the exception of non-claim items (e.g., capitation, provider incentives, etc.).

Schedule 6: Provide a certification by your plan's actuary that the experience for 2006-2007 is accurate and that the assumptions used to project costs during the contract period are reasonable.

Submit Schedules 1 through 6 via e-mail to HFPRates08-09@mrmib.ca.gov. Mail a signed hard copy of Schedule 6 (Actuarial Certification) and a hardcopy of the template to Ms. Jackie Baker c/o MRMIB 1000 G St. Suite 450, Sacramento, CA 95814.

California Healthy Families
July 2008 - June 2009 Infant Rate Development - First 60 Days of Life
Utilization and Cost Experience July 2006 through June 2007
Fill out one for each Region and Statewide (if applicable)

Schedule 1

Plan Name _____

Description of Experience Data _____

(Specify Region or Statewide) _____

Member Months for July 2006 - June 2007

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
	Description of Units (e.g., days, claims, units of service)	Total Cost	Total Units	Annual Units per 1000 Members	Gross Cost per Unit	Copay per Unit	Net Cost per Unit	Cost PMPM
Health care services								
Inpatient Hospital								
Med/Surg					\$ -		\$ -	\$ -
Newborn					\$ -		\$ -	\$ -
Capitation								
Provider Incentive Payments								
Total								\$ -
Outpatient Hospital & Surgical Center								
Emergency Room					\$ -		\$ -	\$ -
Clinic					\$ -		\$ -	\$ -
Capitation								
Provider Incentive Payments								
Total								\$ -
Professional								
Well baby/child					\$ -		\$ -	\$ -
Immunizations/injections					\$ -		\$ -	\$ -
Physician office visits					\$ -		\$ -	\$ -
Surgery					\$ -		\$ -	\$ -
Capitation								
Provider Incentive Payments								
Total								\$ -
Ancillary Services								
Diagnostic x-ray/lab					\$ -		\$ -	\$ -
DME & Supplies					\$ -		\$ -	\$ -
Prescription drugs					\$ -		\$ -	\$ -
Other					\$ -		\$ -	\$ -
Capitation								
Net Reinsurance Costs								
UM/QA Costs								
Total								\$ -
Grand total including Provider Incentive Payments								\$ -
Provider Incentive Payments								\$ -
Grand total excluding Provider Incentive Payments								\$ -
Total Health Care Expenditures								\$ -

California Healthy Families

Schedule 2

July 2008 - June 2009 Infant Rate Development - First 60 Days of Life

Assumptions used to project costs to July 2008 - June 2009

Fill out one for each Region

Plan Name _____

Specify Region _____

Months of Trend (should be 24 if data from 2006/2007 contract year used as the base):

If different than 24, please explain: _____

Health care services

Inpatient Hospital

Med/Surg

Newborn

Capitation

Provider Incentive Payments

Total

Annualized Trend Rates		
Utilization	Unit Cost	PMPM

		0.00%
		0.00%

Trend Factors		
Utilization	Unit Cost	PMPM

1.000	1.000	1.000
1.000	1.000	1.000
		1.000
		1.000

Other Adjustments	
Factors	Description

1.000	
1.000	
1.000	
1.000	
1.000	

Outpatient Hospital & Surgical Center

Emergency Room

Clinic

Capitation

Provider Incentive Payments

Total

		0.00%
		0.00%

1.000	1.000	1.000
1.000	1.000	1.000
		1.000
		1.000

1.000	
1.000	
1.000	
1.000	

Professional

Well baby/child

Immunizations/injections

Physician office visits

Surgery

Capitation

Provider Incentive Payments

Total

		0.00%
		0.00%
		0.00%
		0.00%

1.000	1.000	1.000
1.000	1.000	1.000
1.000	1.000	1.000
1.000	1.000	1.000
		1.000
		1.000

1.000	
1.000	
1.000	
1.000	
1.000	
1.000	

Ancillary Services

Diagnostic x-ray/lab

DME & Supplies

Prescription drugs

Other

Capitation

Net Reinsurance Costs

UM/QA Costs

Total

		0.00%
		0.00%
		0.00%
		0.00%

1.000	1.000	1.000
1.000	1.000	1.000
1.000	1.000	1.000
1.000	1.000	1.000
		1.000
		1.000
		1.000

1.000	
1.000	
1.000	
1.000	
1.000	
1.000	
1.000	

Grand total

Source of trend assumptions:

Other Adjustments:

Fill out one for each Region

Specify Region

Inpatient Hospital

(A)	(B)	(C)	(D)	(E)
Annual Units per 1000 Members	Gross Cost per Unit	Copay per Unit	Net Cost per Unit	Cost PMPM
	\$ -	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -	\$ -
				\$ -
				\$ -
				\$ -

Emergency Room

	\$ -	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -	\$ -
				\$ -
				\$ -
				\$ -

Professional

Well baby/child	\$ -	\$ -	\$ -	\$ -
Immunizations/injections	\$ -	\$ -	\$ -	\$ -
Physician office visits	\$ -	\$ -	\$ -	\$ -
Surgery	\$ -	\$ -	\$ -	\$ -
Capitation				\$ -
Provider Incentive Payments				\$ -
Total				\$ -

Ancillary Services

Diagnostic x-ray/lab	\$ -	\$ -	\$ -	\$ -
DME & Supplies	\$ -	\$ -	\$ -	\$ -
Physical & Occupational Therapy	\$ -	\$ -	\$ -	\$ -
Other	\$ -	\$ -	\$ -	\$ -
Capitation				\$ -
Net Reinsurance Costs				\$ -
UM/QA Costs				\$ -
Total				\$ -

California Healthy Families
July 2008 - June 2009 Infant Rate Development - First 60 Days of Life
California Children's Services Adjustment

Schedule 3B

 Plan Name

 (Specify Region or Statewide)

Health care services

Program Adjustments:

Reduction for California Children's Services

Total health care costs after adjustments

Cost PMPM
\$ -

California Healthy Families

Schedule 4

July 2008 - June 2009 Infant Rate Development - First 60 Days of Life

Administrative Costs and Rate Projection

Plan Name _____

Specify Region _____

Administrative costs

Claims processing, data processing, customer service

General administrative overhead

Marketing: Communication, education, printing

Provider contracting, managed care network maintenance

Risk charges (identify) _____

Profit

Other (identify) _____

Total administrative costs

Total health care costs from Schedule 3B

Total health care costs plus administrative costs (total per member per month premium)

Cost PMPM	Percent of premium
	0.00%
	0.00%
	0.00%
	0.00%
	0.00%
	0.00%
	0.00%
\$ -	0.00%
\$ -	0.00%
\$ -	0.00%

California Healthy Families

Schedule 5

July 2008 - June 2009 Infant Rate Development - First 60 Days of Life

Program Cost Experience for July 2006 through June 2007

Claim Payment Distribution

Plan Name	Line of Business		(Specify Region or Statewide)	
Payment Range	Total Payments	Number of Claimants	Average Cost per Claimant	Distribution of Claimants
\$0 - \$5,000			#DIV/0!	#DIV/0!
\$5,001 - \$10,000			#DIV/0!	#DIV/0!
\$10,001 - \$20,000			#DIV/0!	#DIV/0!
\$20,001 - \$30,000			#DIV/0!	#DIV/0!
\$30,001 - \$40,000			#DIV/0!	#DIV/0!
\$40,001 - \$50,000			#DIV/0!	#DIV/0!
\$50,001 - \$75,000			#DIV/0!	#DIV/0!
\$75,001 - \$100,000			#DIV/0!	#DIV/0!
\$100,001 - \$150,000			#DIV/0!	#DIV/0!
\$150,001 - \$200,000			#DIV/0!	#DIV/0!
\$200,001 - \$300,000			#DIV/0!	#DIV/0!
\$300,001 - \$500,000			#DIV/0!	#DIV/0!
\$500,001 +			#DIV/0!	#DIV/0!
Total	\$ -	-	#DIV/0!	#DIV/0!

California Healthy Families

Schedule 6

July 2008 - June 2009 Infant Rate Development - First 60 Days of Life

Projected costs for July 2008 - June 2009

Certification of Claims Experience and Cost Projections

Plan Name

I certify that the claims experience and cost projections are accurate and appropriate for the California Healthy Families Program.

By:

Print name

Date

Signature & Title

Phone number